

RDERS
 Peay, Stratton

DP-4246

29. 23

11-4-74

1. *Journal of the American Medical Association*, 1997; 277: 1033-1036.

SETG

②

NKDA

Self-Medication Program ☐ Yes ☐ No

DO NOT USE THIS SHEET
UNLESS A RED NUMBER SHOWS

Date/
Military
~~Time~~

| Prob # | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | 32 | 33 | 34 | 35 | 36 | 37 | 38 | 39 | 40 | 41 | 42 | 43 | 44 | 45 | 46 | 47 | 48 | 49 | 50 | 51 | 52 | 53 | 54 | 55 | 56 | 57 | 58 | 59 | 60 | 61 | 62 | 63 | 64 | 65 | 66 | 67 | 68 | 69 | 70 | 71 | 72 | 73 | 74 | 75 | 76 | 77 | 78 | 79 | 80 | 81 | 82 | 83 | 84 | 85 | 86 | 87 | 88 | 89 | 90 | 91 | 92 | 93 | 94 | 95 | 96 | 97 | 98 | 99 | 100 |
|-----------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|-----|
| 1 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | 32 | 33 | 34 | 35 | 36 | 37 | 38 | 39 | 40 | 41 | 42 | 43 | 44 | 45 | 46 | 47 | 48 | 49 | 50 | 51 | 52 | 53 | 54 | 55 | 56 | 57 | 58 | 59 | 60 | 61 | 62 | 63 | 64 | 65 | 66 | 67 | 68 | 69 | 70 | 71 | 72 | 73 | 74 | 75 | 76 | 77 | 78 | 79 | 80 | 81 | 82 | 83 | 84 | 85 | 86 | 87 | 88 | 89 | 90 | 91 | 92 | 93 | 94 | 95 | 96 | 97 | 98 | 99 | 100 |

Time
12/9/01
7:00
12-9-01/28 Tylenol 325, IT 10 4 80 PWR x 30 SAYS
7:00 BV Zoster 150, T 10 BIDS x 30 SAYS
✓ Schedule for Zoster since this week
noted 12/4/01 @ 1250 eysler

ANTHONY IACCARINO D.
PHS PHYSICIAN

15/01/21
mg

12-18-01
8⁰⁰

22
B

Schedule for doctor time within next week sent

Noted 12/18/01 1305 M Leung ddp

RECEIVED
FBI
JAN 20 1964

PLEASE USE BALL POINT PEN ONLY

RECEIVED

PHYSICIAN'S ORDERS

DEC 17 2001

MEDICAL RECORDS DEPT
SCI GRATERFORD

Drug Allergies:

Self-Medication Program ☐ Yes ☐ No

Patient Name:

PEAY

Patient Number:

DP 4246

DOB:

5

Institution:

SCIF

(L)

DO NOT USE THIS SHEET
UNLESS A RED NUMBER SHOWS

CHART UNAVAILABLE

Zantac 150mg po BID x 15 days

NOTED 12/14/01 @ 1600 J. Kotoh

SAMUEL KOTOH, M.D.
PHYSICIAN

PLEASE USE BALL POINT PEN ONLY

PHYSICIAN'S ORDERS

Name: Reay, Jonathan
 Inmate Number: DPL 4246
 DOB: 11-4-76
 Institution: SCITG

Drug Allergies: Ø

Self-Medication Program ☐ Yes ☐ No

| Date/ Military Time | Prob # | DO NOT USE THIS SHEET UNLESS A RED NUMBER SHOWS |
|---------------------------|-----------|---|
| 11/5/01 1105 | #18 | <p>Obotruskin series to 2nd sent</p> <p>consign / Mstr</p> <p> Ralph Smith M.D. Physician J.C. KORSZNAK, P.A.C. </p> <p>noted 11/5/01 1105 M. Leueyord</p> |
| 11/16/01 1425 | #20 | <p>Refer chronic disease clinic</p> <p> Samuel Kotoh, M.D. Physician </p> <p>noted 11/16/01 1430 M. Leueyord</p> |
| 11/26/01 1010 | #21 | <p>Repto Bernal 20cc PO PM & BID x 528</p> <p> Ralph Smith M.D. Physician J.C. KORSZNAK, P.A.C. </p> <p>noted 11/26/01 1010 M. Leueyord</p> |

PHYSICIAN'S ORDERS

Drug Allergies:

NKA

Self-Medication Program ☐ Yes ☐ No

Pearl Stratten,
DP4246

DOB: 11-4-76

SCF-GRA

(E)

| Date/ Military Time | Prob # | DO NOT USE THIS SHEET UNLESS A RED NUMBER SHOWS |
|----------------------------|-----------|--|
| 9/24/01 1410 9-24-01 | #18 | <p>① MOM 30cc PO x T dose</p> <p>② Mineral oil 30cc PO x T dose</p> <p><i>Post</i> <i>gued</i></p> <p><i>Noted 9/24/01 1410</i> <i>Ralph Smith M.D.</i> <i>Physician</i> <i>Quisenberry</i> <i>12/12</i></p> |
| 10/13/01 1120 | (E) | <p>Milk of magnesia 30cc po ^{disp. fast} for Spm today</p> <p>Colace 100mg po bid x 1mo. ^{from 72 guen}</p> <p><i>Noted 10/13/01 1120</i> <i>Samuel Kotoh, M.D.</i> <i>Physician</i></p> |
| 10/14/01 1100 | #18 | <p>① Mineral Oil 30cc PO NR</p> <p>② MOM 30cc PO NR</p> <p>③ Melaminil 11 packets = NR</p> <p><i>Noted 10/14/01 1100</i> <i>Ralph Smith M.D.</i> <i>Physician</i> <i>10/16/01</i> <i>J.C. KORSZNAK, PA-C</i></p> |

PLEASE USE BALL POINT PEN ONLY

PHYSICIAN'S ORDERS

Gray, Stratton
DP4246
11-4-74
SCI Area

Drug Allergies: Ø

Self-Medication Program ☐ Yes ☐ No

(D)

| Date/ Military Time | Prob # | DO NOT USE THIS SHEET UNLESS A RED NUMBER SHOWS |
|---------------------------|-----------|--|
| 7/30/01 | | Sick Call |
| 1510 | (13) | 13 Cefprozol # tabs po tid Zmax 150mg po bid Amoxicillin 500mg po bid Metronidazole 500mg po bid x 14 Dys |
| | | Noted 7/30/01 1605 M Leuenyord APRN |
| 8/24/01 | B | Onprry |
| 1730 | | (1) 1/2 tablet Cefate MyTT Now 800mg 0.35 1400 free (2) Zentax 150 TID (3) Naproxen 375 BID (4) Lab - UA / Op IMA / Cox / Ayles - Lynd P-2701 (5) Cef Nae over final w/c |
| | | Noted 8/24/01 1800 B Beddington R |
| 9/7/01 | (A) | - Dispensing - |
| 1120 | (B) | - Dulcetro # tabs po stat qwer. |
| | (13) | - Review to Dispensing 9-11-01 @ 1030 pass qwer |

RALPH W SMITH MD
MEDICINE

DENNIS IACCARINO D.O.
PHS PHYSICIAN

RALPH W SMITH MD
MEDICINE

PLEASE USE BALL POINT PEN ONLY

11/24/01 1635

PHYSICIAN'S ORDERS

RECEIVED
JUN 13 2001

Drug Allergies:

MEDICAL
SCI CENTER

Inmate Name:

Pray, Stratton

Inmate Number:

DP4246

DOB:

11-4-76

Institution:

SCTG

Self-Medication Program ☐ Yes ☐ NoDate/
Military
TimeProb
#DO NOT USE THIS SHEET
UNLESS A RED NUMBER SHOWS

6/11/01 1

Zentac 150, + BID x 2 weeks

A. TACCARDI

noted 6/11/01 1050 M. Leveyo LPPN

6/28/01 1

① UPPY GI
H pylori

M. E. ARBERG MD

noted 6/28/01 1400 M. Leveyo LPPN

7/10/01 13

Sick Call
- Ambuculan 5mg B BID x 7 days
- Bentyl 10mg B BID x 7 daysRALPH W. SMITH MD
MEDICINE

noted 7/10/01 1140 M. Leveyo LPPN

PLEASE USE BALL POINT PEN ONLY

PLEASE USE BALL POINT PEN ONLY

PHYSICIAN'S ORDERS

2 Auto Inject
 Drug Allergies: 1 Products

Inmate Name: Peay, Stratton

Inmate Number: DP 4246

DOB: 11-4-76

Institution: SCIF

Self-Medication Program ☐ Yes ☐ No

| Date/ Military Time | Prob # | DO NOT USE THIS SHEET UNLESS A RED NUMBER SHOWS |
|---------------------------|-----------|---|
| 1/8/01 1015 | 12 | psych consult - sent noted 1/8/01 1022 M. Leung MD |
| 1/31/01 1035 | 8 | ① Penicillin 500mg + STD X 7 days - given on 5/12 Marc Jaffee, D.O. CPS Physician MD noted 1/31/01 1040 M. Leung MD |
| 2/9/01 1055 | (8) | ① surgical clinic (right sided subcutaneous anterior to inguinal) noted 2/9/01 1057 M. Leung MD |
| 5/17/01 1030 | (13) | Sick Call - MAG Citraro & f Bortus Po. - one dose - Penicillin & f VR/dy Po. x 2 wks noted 5/17/01 1030 M. Leung MD |
| 6/1/01 100 | 4A | L - spine xray sent noted 6/1/01 1055 M. Leung MD |
| 7- | | PLEASE USE BALL POINT PEN ONLY |

PHYSICIAN'S ORDERS

Inmate Name:

Play, Stratton

Inmate Number:

DP-4246

DOB:

11-4-76

Institution:

SCIG

Drug Allergies:

Nuts, Not Products

Self-Medication Program ☐ Yes ☐ No

| Date/ Military Time | Prob # | DO NOT USE THIS SHEET UNLESS A RED NUMBER SHOWS |
|---------------------------|-----------|---|
| 11/2/00 | #9 | VTO DR Beken / (FLOOR 255) Emre Beken MD Medical Director |
| 2/30 | | ① STOP eating all nuts |
| | | ② Benadryl 50mg PO stat 8PM 2/45 |
| | | ③ FTM SIC PRD |
| | | Noted 4/2/00 2145 @ FLOOR 255 |
| 11/2/00 | #9 | VTO DR Beken / C Joudrey RNC 9 |
| | | 1M SoluMedrol 125mg stat given 2/45 |
| | | ADM INF For 33° Obs. |
| | | DR Beken To eval in AM |
| 11/3/00 | | Dr. Beken Medical Dir |
| 11/3/00 | #4 | D/C to block |
| 11/3/00 | #4 | CBC, chem R, U/A. |
| 9- | | Emre Beken MD Medical Director |
| | | Noted 11/3/00 1100 |
| 12/18/00 | (11) | Call Sel y x 5d. given on s/c |
| 1038 | | DENNIS MOYER, M.D. |
| | | Noted 12/18/00 1039 M Leung |

PLEASE USE BALL POINT PEN ONLY

8/01
OR
9/01

PHYSICIAN'S ORDERS

(Handwritten circled 'E')

PEAK Strunk

DP4246

114176

SCIG

(Handwritten circled 'D')

Drug Allergies:

Self-Medication Program ☐ Yes ☐ No

DO NOT USE THIS SHEET
UNLESS A RED NUMBER SHOWS

| Date/ Military Time | Prob # | |
|---------------------------|-----------|---|
| 1/24/00 1525 | | <p>① RICE</p> <p>② Mafren 80mg PO TID x 5 days</p> <p><i>(Handwritten: Wsaba 1520 1/24/00)</i></p> <p><i>(Handwritten: 1/6/00 1520)</i></p> |
| 4/26/00 9:30 AM | 5 | <p>① lotrimin cream applied BID x 10 days to scalp</p> <p><i>(Handwritten: noted 4/26/00 094)</i></p> <p>Marc Jaffee, D.O. CPS Physician <i>(Signature)</i></p> |
| 7/6/00 #7 1040 | | <p>Amoxil 25mg TID x 10d.</p> <p>Cold set up x 5d.</p> <p>Richard Benoit, D.O. CPS Physician <i>(Signature)</i></p> |
| 10/25/00 11/10 AM | (8) | <p>① Keflex 500mg TID x 7 days</p> <p>Marc Jaffee, D.O. CPS Physician <i>(Signature)</i></p> <p><i>(Handwritten: noted 10/25/00 1114)</i></p> |

PLEASE USE BALL POINT PEN ONLY

PHYSICIAN'S ORDERS

Inmate Name:

Pearcy, S

Inmate Number:

DP 4246

DOB:

(E) 0216

Institution:

SCIV

SCIV

Drug Allergies:

Self-Medication Program ☐ Yes

☐ No

| Date/ Military Time | Prob # | DO NOT USE THIS SHEET UNLESS A RED NUMBER SHOWS |
|---------------------------|-----------|--|
| 9/3/99 | (2) | |
| 0913 | | 1) Bactrim DS $\dot{\bar{i}}$ po Bid x 7 d |
| | | Noted 9/3/99 [Signature] 1400 |
| | | N. Kulayiat, MD Internal Medicine |
| | | Sick Call. |
| 9/16/99 | | Motrin 600mg po TID x 7 days. |
| MD | #1 | Amoxicillin 500 mg po TID x 7 days |
| | | [Signature] |
| | | Emre Beken MD CPS Physician |
| | | Noted 9/16/99 0915 [Signature] L Balc |
| 10/28/99 | | Kelex 500mg $\dot{\bar{i}}$ po tid x 10 d. |
| #2 | | |
| 1015 | | |
| | | Richard Benoit, D.O. CPS Physician |
| | | Noted 10/28/99 [Signature] [Signature] |
| 1/10/00 | (3) | TAB outmost TID x 5 d. |
| 0957 | | |
| | | [Signature] |
| | | DENNIS MOYER, M.D. |
| | | Noted 1/10/2000 1000 [Signature] |

PLEASE USE BALL POINT PEN ONLY

PHYSICIAN'S ORDERS

Drug Allergies:

NKDA

Patient Name:

Reay, Stratton

Patient Number:

DP4246

DOB:

11/4/76

Institution:

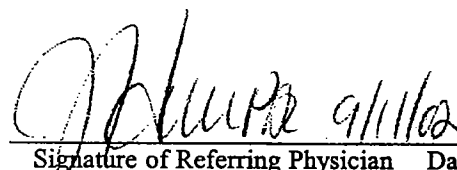
E

Self-Medication Program ☐ Yes ☐ No

| Date/ Military Time | Prob # | DO NOT USE THIS SHEET UNLESS A RED NUMBER SHOWS |
|---------------------------|-----------|---|
| 12/24/98 | | ① Tagamet 1 tab PO BID x 2 wks (300 mg) ② Maalox 30 cc PO TID x 2 wks. noted 1000 12/24/98 Theresa M. SALOMON |
| 4/19/99 | 1408 | Hiv test DENNIS MOYER, M.D. noted 4/19/99 1408 BPlanck EBK |
| 4/29/99 | #10 | ① Flat Abdomen x Ray ✓done ② Reptohernat 30 cc no pain (var) ✓done ③ Follow up 1 wk ④ Advice to wear back if any clings. ⑤ Tagamet 800 mg PO BID for 2 wks. noted 4/29/99 1324 hrs - E Block Miguel Salomon, M.D. CPS Physician |

PLEASE USE BALL POINT PEN ONLY

CONSULTATION RECORD

| | | | | | |
|--|-----------------------------------|---|---|--|--|
| Part A: Completed by referring facility: | | Type of Consult: (Circle) Initial Follow-up On-Site Off-site Telemedicine | | | |
| Referred to: <i>BANDMEREKIA</i> | Referred by: <i>THORNTON</i> | Appt. Date/Time: | | | |
| Specialty: | Drug Sensitivity: <i>IVKHA</i> | Copies of relevant health information attached: (circle) Yes No | | | |
| Reason for Referral/History of Present Illness/Injury: <i>CHRONIC CONSTIPATION 14 YRS. Treated with LAXATIVES. SUCCESS. LOST HAVE SUCCESS. MONITORING. BUT CONSTIPATION CAME BACK. Had laparotomy in 1996 2° GSW. HAS MIDLINE SCAR. X RAYS SHOW CONSTIPATION.</i> | | | | | |
| Treatment to Date/Current Medications and Significant Medication History: | | | | | |
|  Signature of Referring Physician Date | | | | | |
| Reviewed by Medical Director: (Circle) | Approval | Disapproval | Forwarded to UR (Date): | | |
| Medical Director Signature: | Date: | | | | |
| UR Decision: (Circle) | Approval | Disapproval | Date: | | |
| Part B: To be completed by consulting Physician and returned with officer to the institution: | | | | | |
| | | | | | |
| Signature of Medical Director Date/Time | | | Signature of Consulting Physician Date/Time | | |

Consultation Record
Commonwealth of Pennsylvania
Department of Corrections
DC-441
 (Revised: 1-01)

Inmate Name: *Reay, Shatton*
 Inmate Number: *DP4246*
 DOB: *11/4/76*
 Facility: *GA*

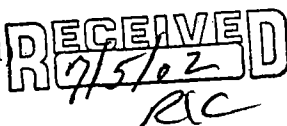
9/10
87

CONSULTATION RECORD

| | | | |
|--|---|---|--|
| Part A: Completed by referring facility: | | Type of Consult: (Circle) Initial Follow-up On-Site Off-site Telemedicine | |
| Referred to: <i>GASTROENTEROLOGY</i> | Referred by: <i>A. IACCARINO</i> | Appt. Date/Time: | |
| Specialty: | Drug Sensitivity: <i>NKDA</i> | Copies of relevant health information attached: (circle) <input checked="" type="radio"/> Yes <input type="radio"/> No | |
| Reason for Referral/History of Present Illness/Injury: <i>Chronic abd pain > 1 Year obstructive severe moderate constipation</i> <i>Chronic Constipation > 1 Year</i> <i>Please evaluate for endoscopy and/or colonoscopy</i> | | | |
| Treatment to Date/Current Medications and Significant Medication History: <i>Colace</i> | | | |
| Reviewed by Medical Director: (Circle) Approval Disapproval | | Forwarded to UR (Date): | |
| Medical Director Signature: <i>[Signature]</i> | RALPH W. SMITH, MD MEDICAL DOCTOR | Date: | |
| UR Decision: (Circle) Approval Disapproval | Date: | | |
| Part B: To be completed by consulting Physician and returned with officer to the institution: | | | |
| <p>RECEIVED</p> <p>JUL 10 2002</p> <p>MEDICAL RECORDS DEPT.</p> <p>SCI GRATERFORD</p> | | | |
| Signature of Medical Director Date/Time | | Signature of Consulting Physician Date/Time | |

Consultation Record
Commonwealth of Pennsylvania
Department of Corrections
DC-441

(Revised: 1-01)



Inmate Name: *PEAY, STRATTON*

Inmate Number: *DP 4246*

DOB: *11-4-76*

Facility: *SCI Graterford*

dit
7-4
1100

CONSULTATION RECORD

| | | | | | |
|--|-------------------------------------|---|--|--|--|
| Part A: Completed by referring facility: | | Type of Consult: (Circle) Initial Follow-up On-Site Off-site Telemedicine | | | |
| Referred to: <i>Gastroenterology</i> | Referred by: <i>A. Iaccarino</i> | Appt. Date/Time: | | | |
| Specialty: | Drug Sensitivity: | Copies of relevant health information attached: (circle) <i>Yes</i> No | | | |
| Reason for Referral/History of Present Illness/Injury: <i>Chronic abd pain > 1 year</i> <i>Chronic constipation > 1 year</i> <i>? etiology of abd pain</i> <i>No IBS</i> <i>obstruction series neg</i> | | | | | |
| Treatment to Date/Current Medications and Significant Medication History: <i>please evaluate for endoscopy</i> <i>Mineral oil</i> <i>antacid</i> ANTHONY IACCARINO D.O. FMS PHYSICIAN <i>[Signature]</i> <i>6-12-02</i> Signature of Referring Physician Date | | | | | |
| Reviewed by Medical Director: (Circle) Approval <u>Disapproval</u> | | Forwarded to UR (Date): | | | |
| Medical Director Signature: <i>[Signature]</i> RALPH W. SMITH, MD MEDICAL DOCTOR Date: <i>6/9/02</i> | | | | | |
| UR Decision: (Circle) Approval <u>Disapproval</u> | | Date: | | | |
| Part B: To be completed by consulting Physician and returned with officer to the institution: | | | | | |
| <p>RECEIVED</p> <p>JUN 20 2002</p> <p>MEDICAL RECORDS DEPT. SCI GRATERFORD</p> <p><i>As Per DC 42</i></p> <p><i>[Signature]</i> Ralph Smith M.D. <i>6-9-02</i> Physician Signature of Medical Director Date/Time</p> <p>Signature of Consulting Physician Date/Time</p> | | | | | |

Consultation Record
Commonwealth of Pennsylvania
Department of Corrections
DC-441

(Revised)

RECEIVED
6/14/02

Inmate Name:

PEAY, Stratton

Inmate Number:

DP 4246

DOB:

11-4-76

Facility:

SCI 6

6/12/02
SM

CONSULTATION RECORD

| | | | | | |
|--|--------------------------------------|---|-------------------------|--|--|
| Part A: Completed by referring facility: | | Type of Consult: (Circle) Initial Follow-up On-Site Off-site Telemedicine | | | |
| Referred to: <i>Sigmoidoscopy</i> | Referred by: <i>Dr. Joffe</i> | Appt. Date/Time: | | | |
| Specialty: | Drug Sensitivity: | Copies of relevant health information attached: (circle) Yes No | | | |
| Reason for Referral/History of Present Illness/Injury: <i>had been raped months ago (rectal bleeding, constipation and pain (defecation))</i> | | | | | |
| Treatment to Date/Current Medications and Significant Medication History: | | | | | |
| <div style="text-align: right;"> RECEIVED APR 30 2002 MEDICAL RECORDS DEPT SCI GRATERFORD <i>Marek Joffe MD</i> 3/27/02 Signature of Referring Physician Date </div> | | | | | |
| Reviewed by Medical Director: (Circle) | Approval | Disapproval | Forwarded to UR (Date): | | |
| Medical Director Signature: <i>R</i> | RALPH W. SMITH, MD MEDICAL DOCTOR | | Date: <i>3-28-02</i> | | |
| UR Decision: (Circle) | Approval | Disapproval | Date: | | |
| Part B: To be completed by consulting Physician and returned with officer to the institution: | | | | | |
| <div style="display: flex; justify-content: space-between;"> <div>Signature of Medical Director Date/Time</div> <div>Signature of Consulting Physician Date/Time</div> </div> | | | | | |

Consultation Record
Commonwealth of Pennsylvania
Department of Corrections

DC-441

(Revised: 1-01)

RECEIVED
3-28-02

Inmate Name:

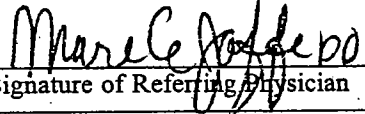


Inmate Number:

DOB:

Facility:

Peay Stritton
DP-4246
11-4-76
SCG

CONSULTATION RECORD

| | | | |
|---|---|---|-------------------------|
| Part A: Completed by referring facility: | | Type of Consult: (Circle) Initial Follow-up On-Site Off-site Telemedicine | |
| Referred to: Sigmoidoscopy | Referred by: Dr. Jaffe | Appt. Date/Time: --- | |
| Specialty: | Drug Sensitivity: | Copies of relevant health information attached: (circle) Yes No | |
| Reason for Referral/History of Present Illness/Injury: had been raped months ago (rectal bleeding, constipation, and pain (defecation)) | | | |
| Treatment to Date/Current Medications and Significant Medication History: | | | |
| | |  Signature of Referring Physician Date 3/2 | |
| Reviewed by Medical Director: (Circle) | Approval | Disapproval | Forwarded to UR (Date): |
| Medical Director Signature:  |  | | Date: 3/28/22 |
| UR Decision: (Circle) | Approval | Disapproval | Date: |
| Part B: To be completed by consulting Physician and returned with officer to the institution: | | | |
| <div style="display: flex; justify-content: space-between;"> <div>Signature of Medical Director Date/Time</div> <div>Signature of Consulting Physician Date/Time</div> </div> | | | |

Consultation Record
Commonwealth of Pennsylvania
Department of Corrections

DC-441

(Revised: 1-01)

Inmate Name:

Inmate Number:

DOB:

Facility:

CONSULTATION RECORD

| CONSULTATION RECORD | | | |
|---|--------------------|---|--|
| Part A: Completed by referring facility: | | Type of Consult: (Circle) Initial Follow-up On-Site Off-site Telemedicine | |
| Referred to: | Referred by: | Appt. Date/Time: | |
| Gastroenterology | Luis MARTINEZ, PAC | | |
| Specialty: | Drug Sensitivity: | Copies of relevant health information attached: (circle) Yes No | |
| | NEDA | | |
| Reason for Referral/History of Present Illness/Injury: | | | |
| Chronic constipation | | | |
| Treatment to Date/Current Medications and Significant Medication History: | | | |
| Colace metamucil milk of Mag. Dulcolax. | | | |
| Reviewed by Medical Director: (Circle) | | Signature of Referring Physician Date | |
| Medical Director Signature: [Signature] | | Luis Martinez 3/15/0 | |
| Approval | | Forwarded to UR (Date): | |
| Disapproval | | | |
| RALPH W. SMITH, MD MEDICAL DOCTOR | | Date: 3-18-02 | |
| UR Decision: (Circle) | | Date: | |
| Approval | | | |
| Disapproval | | | |
| Part B: To be completed by consulting Physician and returned with officer to the institution: | | | |
| As Per DC 472 | | | |
| Signature of Medical Director Date/Time | | Signature of Consulting Physician Date/Time | |
| [Signature] 3-18-02 | | [Signature] 13w | |

Consultation Record
Commonwealth of Pennsylvania
Department of Corrections
DC-441

(Revised: 1-01)

RECEIVED
318702

WHITE: Medical Record

Inmate Name:

Peay, S.
DP 4246

⑦

Inmate Number:

SC/G

DOB:

Facility:

CANARY: Consultant

PINK: Medical Record (Pending)

No. _____

CONSULTATION RECORD

| | | | |
|---|--|---|--|
| Part A: To be completed by referring institution: | | Type of Consult: <input checked="" type="checkbox"/> Initial [] Follow-up [] On-Site [] Off-Site | |
| Referred to: <i>MSC</i> | Referred by: (physician name) <i>Dr. Jaffee</i> | Appt. Date: <i>7/12</i> | |
| Specialty: | | Appt. Time: | |
| Drug Sensitivity: <input checked="" type="checkbox"/> No [] Yes (Specify) | | | |
| Copies of lab and X-ray results attached? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> If yes, specify: | | | |
| Reason for Referral: <i>right sebaceous cyst refractory to course of antibiotics</i> | | | |
| History of Injury/Problem: | | Date of Onset: <i>1 year ("comes & goes")</i> | |
| Treatment to Date/Current Medications and Significant Medication History: | | | |
| | | Marc Jaffee, D.O. CPS Physician <i>[Signature]</i> <i>10502/9/01</i> Signature of Referring Physician Date | |
| <input checked="" type="checkbox"/> Approval [] Disapproval | | Medical Director Signature: <i>[Signature]</i> Date: <i>7/4/01</i> | |
| Transmittal Date: | | Transmitted By: <i>Emre Beken MD</i> | |
| Approval Date: | | Approved By: <i>[Signature]</i> Medical Director | |
| Part B: To be completed by consulting Physician and returned with officer to the institution: | | | |
| Diagnosis and Recommendations: <i>Showed but not seen, DR - 3/12/01</i> <i>4/9/01 - No show - DR</i> <i>Eval - re-eval. Resolving pre antibiotic seb cyst that is nearly resolved & doesn't need surgery @ this time</i> Dennis Moyer, M.D. Surgical Clinic <i>[Signature]</i> <i>4/23/01</i> <i>1520</i> Signature of Consulting Physician Date | | | |

Consultation Record
 Commonwealth of Pennsylvania
 Department of Corrections
 DC-441

RECEIVED
 10502/9/01

WHITE: Medical Record

Inmate Name: *Peay, Stratton*Inmate Number: *D P 4246*DOB: *11-4-76*Institution: *SCITG*

CANARY: Consultant

PINK: Medical Record (Pending)

JAN 20 2001

MEDICAL RECORDS DEPT.
SCI GRATERFORD

No. _____

CONSULTATION RECORD

| | | | |
|---|---|---|--|
| Part A: To be completed by referring institution: | | Type of Consult: <input checked="" type="checkbox"/> Initial [] Follow-up <input checked="" type="checkbox"/> On-Site [] Off-Site | |
| Referred to: <i>Play</i> | Referred by: (physician name) <i>Dr. Moyer</i> | Appt. Date: | |
| Specialty: | | Appt. Time: | |
| Drug Sensitivity: <input checked="" type="checkbox"/> No [] Yes (Specify) | | | |
| Copies of lab and X-ray results attached? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> If yes, specify: | | | |
| Reason for Referral: <i>? Reprimand</i> | | | |
| History of Injury/Problem: <i>Claims he is severely emotionally dependent</i> | | Date of Onset: | |
| Treatment to Date/Current Medications and Significant Medication History: <i>None</i> <i>place and for tx</i> | | | |
| | | <i>[Signature]</i> DENNIS MOYER, MD <i>1/20/01</i> Signature of Referring Physician Date | |
| <input checked="" type="checkbox"/> Approval [] Disapproval | | Medical Director Signature: <i>[Signature]</i> Date: <i>1/10/01</i> | |
| Transmittal Date: | | Transmitted By: <i>Emre Beken MD</i> Medical Director | |
| Approval Date: | | Approved By: | |
| Part B: To be completed by consulting Physician and returned with officer to the institution: | | | |
| Diagnosis and Recommendations: <i>pt did NOT want to talk about anything -</i> <i>he said "This is crazy" - he was</i> <i>polite & smiling BUT was NOT going to</i> <i>discuss anything - he said "I am not</i> <i>now" - Can I leave?</i> <i>AND he kept it.</i> | | | |
| | | <i>[Signature]</i> <i>1/19/01</i> Signature of Consulting Physician Date | |

Consultation Record
Commonwealth of Pennsylvania
Department of Corrections
DC-441

Inmate Name: *Play, S*
Inmate Number: *DP-4246*
DOB: *11-4-76*
Institution: *SCITG*

RECEIVED
1-9-01

No. _____

CONSULTATION RECORD

| | | | | | |
|--|--|---|-------------|--|------|
| Part A: To be completed by referring institution: | | Type of Consult: [] Initial [] Follow-up [] On-Site [] Off-Site | | | |
| Referred to: <i>HIV testing</i> | Referred by: (physician name) <i>Dr Moyer</i> | | Appt. Date: | | |
| Specialty: | <i>Sick call</i> | | Appt. Time: | | |
| Drug Sensitivity: [X] No [] Yes (Specify) | | | | | |
| Copies of lab and X-ray results attached? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> If yes, specify: | | | | | |
| Reason for Referral: <i>Vague Complaint</i> | | | | | |
| History of Injury/Problem: | | Date of Onset: | | | |
| <i>Relate vague GI Complaint</i> | | | | | |
| <i>Agreed to be tested - See H&E 1/26/99</i> | | | | | |
| Treatment to Date/Current Medications and Significant Medication History: <i>None</i> | | | | | |
| | | <i>1401</i> <i>Dennis Moyer, M.D.</i> Signature of Referring Physician Date | | | |
| <input checked="" type="checkbox"/> Approval [] Disapproval | | Medical Director Signature: <i>[Signature]</i> Date: <i>9-20-99</i> | | | |
| Transmittal Date: | | Transmitted By: | | | |
| Approval Date: | | Approved By: | | | |
| Part B: To be completed by consulting Physician and returned with officer to the institution: | | | | | |
| Diagnosis and Recommendations: <i>5-4-99 HIV pre-test counseling</i> <i>consent signed</i> <i>lab drawn</i> <i>M. Becherer</i> | | | | | |
| Signature of Consulting Physician | | | | | Date |

Consultation Record

Commonwealth of Pennsylvania

Department of Corrections

DC-441

Inmate Name: *Peay, Stratton*Inmate Number: *DP4246*DOB: *11-4-76*Institution: *SCSC**E B203*

RECEIVED
MAY 07 1999
DEPT. OF CORRECTIONS
SCS

WHITE: Medical Record

CANARY: Consultant

PINK: Medical Record (Pending)

[Signature]

No. _____

CONSULTATION RECORD

| | | | |
|--|--|---|-------|
| Part A: To be completed by referring institution: | | Type of Consult: <input type="checkbox"/> Initial <input type="checkbox"/> Follow-up <input type="checkbox"/> On-Site <input type="checkbox"/> Off-Site | |
| Referred to : <i>HIV clinic</i> | Referred by: (physician name) <i>Dr Solomon</i> | Appt. Date: | |
| Specialty: | | Appt. Time: | |
| Drug Sensitivity: <input type="checkbox"/> No <input type="checkbox"/> Yes (Specify) | | | |
| Copies of lab and X-ray results attached? Yes No If yes, specify: | | | |
| Reason for Referral: | | | |
| History of Injury/Problem: <i>HIV test.</i> | | Date of Onset: <i>22 Y WBH who had lost of weight & febrile.</i> | |
| Treatment to Date/Current Medications and Significant Medication History: | | | |
| | | <i>M. Hall</i> 12/24/99 Signature of Referring Physician Date | |
| <input type="checkbox"/> Approval <input type="checkbox"/> Disapproval | | Medical Director Signature: | Date: |
| Transmittal Date: | | Transmitted By: | |
| Approval Date: | | Approved By: | |
| Part B: To be completed by consulting Physician and returned with officer to the institution: | | | |
| Diagnosis and Recommendations: <i>1/26/99 Inmate seen - given education on HIV-ref. test M. Becerra</i> | | | |
| | | Signature of Consulting Physician Date | |

Consultation Record
Commonwealth of Pennsylvania
Department of Corrections
DC-441

Inmate Name:

Inmate Number:

DOB:

Institution:

RECEIVED

JAN 29 1999

MEDICAL RECORDS DEPT
SCI GRATERFORD

CANARY: Consultant

PINK: Medical Record (Pending)

(10)

No. _____

CONSULTATION RECORD

| | | | |
|--|--|---|-------------|
| Part A: To be completed by referring institution: | | Type of Consult: <input type="checkbox"/> Initial <input type="checkbox"/> Follow-up <input type="checkbox"/> On-Site <input type="checkbox"/> Off-Site | |
| Referred to: <i>MSC</i> | Referred by: (physician name) <i>Samre Beken M.D. OPB Physician</i> | Appt. Date: <i>12-8</i> | Appt. Time: |
| Specialty: | | | |
| Drug Sensitivity: <input type="checkbox"/> No <input type="checkbox"/> Yes (Specify) | | | |
| Copies of lab and X-ray results attached? Yes No If yes, specify: | | | |
| Reason for Referral: | | | |
| History of Injury/Problem: <i>35 YO male has small cyst at the ant. aspect of the ear, please evaluate for removal.</i> | | Date of Onset: <i>11-17-98</i> | |
| Treatment to Date/Current Medications and Significant Medication History: | | | |
| | | Signature of Referring Physician <i>[Signature]</i> Date <i>11-17-98</i> | |
| <input checked="" type="checkbox"/> Approval <input type="checkbox"/> Disapproval | Medical Director Signature: <i>[Signature]</i> Date: <i>11-20-98</i> | | |
| Transmittal Date: | Transmitted By: | Peter Baddick, D.O. Medical Director | |
| Approval Date: | Approved By: | | |
| Part B: To be completed by consulting Physician and returned with officer to the institution: | | | |
| Diagnosis and Recommendations: <i>Seb. Cyst at [P] no infection area. Was infected. Re-examine Re-schedule for next clinic 12/17/98 - Re-exam shows no significant lesion for excision Dennis Moyer, M.D.</i> | | | |
| | | Signature of Consulting Physician <i>[Signature]</i> Date <i>12/17/98</i> | |

Consultation Record
Commonwealth of Pennsylvania
Department of Corrections
DC-441

RECEIVED

DEC 21 1998

MEDICAL RECORDS DEPT
SCI GRATERFORD

Institution:

SCI - Stra

WHITE: Medical Record

CANARY: Consultant

PINK: Medical Record (Pending)

| | | | |
|--|---------------------------------|---|--|
| DC-456 | | RECEIVED COMMONWEALTH OF PENNSYLVANIA DEPARTMENT OF CORRECTIONS JUL 19 2002 | |
| X-RAY REPORT | | | |
| NAME <i>Peary, Strath</i> | NUMBER <i>DP 4246</i> | QUARTERS MEDICAL RECORDS DEPT. SCI GRATERFORD | |
| X-RAY NUMBER | DATE OF X-RAY <i>6-12-02</i> | TECHNICIAN <i>BR</i> | |
| <input type="checkbox"/> TREATMENT Diagnostic Reports DETAILS: Name: <i>PALETTI SMITH, MD</i> Date / Time: <i>6-17-02 1:30</i> <i>A N NCS</i> <i>Supine + Erect abd films</i> <i>ANTHONY IACCARINO, D.O.</i> <i>PHYSICIAN</i> | | | |
| REPORT ABDOMEN- Radiographs of the abdomen demonstrate moderate constipation. There is no evidence of obstruction or free air. There are no unusual calcifications or calculi. There are phleboliths in the pelvis bilaterally. A bullet is noted overlying the left femoral head. IMPRESSION- Moderate constipation. No obstruction. PETER G. GREGORY, M.D. DATE OF REPORT 06-13-02 lag <i>ROENTGENOLOGIST</i> | | | |
| White—MEDICAL RECORD | | Canary—X-RAY FILE | |

| | | | |
|--|--------------------------------|---|--|
| DC-456 | | RECEIVED SEP 24 2002 COMMONWEALTH OF PENNSYLVANIA DEPARTMENT OF CORRECTIONS | |
| X-RAY REPORT | | | |
| NAME <i>PEAY</i> | NUMBER <i>DP 4246</i> | QUARTERS <i>L-BIK</i> | |
| X-RAY NUMBER | DATE OF X-RAY <i>9/5/02</i> | TECHNICIAN <i>BR</i> | |
| <input type="checkbox"/> TREATMENT <input type="checkbox"/> EXAMINATION Diagnostic Reports DETAILS: Name: <i>Peary, Strath</i> Date / Time: <i>9/10/02 11:00 AM</i> <i>A N NCS</i> <i>Immediate closed film</i> <i>will be used for future damage</i> <i>Joe Natta</i> <i>ANTHONY IACCARINO, D.O.</i> <i>PHYSICIAN</i> | | | |
| REPORT ABDOMEN- There are some unusual calcifications projecting over the left transverse process of L-2. This could be something within the GI tract but calcifications of the left renal gland cannot be excluded. Phleboliths are seen in the pelvis. Clinical correlation will be important. Bulla is seen projecting over the left femoral head with some sclerosis of the femoral head which maybe related to trauma and associated degenerative changes but without previous film this is difficult to determine. THOMAS DOVDAITIS, M.D. DATE OF REPORT 09/06/02 lag <i>ROENTGENOLOGIST</i> | | | |
| White—MEDICAL RECORD | | Canary—X-RAY FILE | |

Pink—RADIOLOGIST FILE

| | | | |
|------------------------------------|--------------------------------------|---|--|
| DC-456 | | COMMONWEALTH OF PENNSYLVANIA DEPARTMENT OF CORRECTIONS | |
| X-RAY REPORT | | | |
| NAME <i>Peay</i> | NUMBER <i>DP 4246</i> | QUARTERS <i>E</i> | |
| X-RAY NUMBER | DATE OF X-RAY | TECHNICIAN | |
| <input type="checkbox"/> TREATMENT | <input type="checkbox"/> EXAMINATION | DETAILS: <i>KUB [by report]</i> | |
| REPORT | | PHYSICIAN <i>5. KOTB Hm</i> | |
| DATE OF REPORT | | ROENTGENOLOGIST | |

*(inmate refund)
DC 462 done*

White—MEDICAL RECORD Canary—X-RAY FILE Pink—RADIOLOGIST FILE

4/25/02

| | | | |
|--|--------------------------------------|---|--|
| DC-456 | | COMMONWEALTH OF PENNSYLVANIA DEPARTMENT OF CORRECTIONS | |
| X-RAY REPORT | | | |
| NAME <i>PERY, S</i> | NUMBER <i>DP 4246</i> | QUARTERS <i>E-B1085</i> | |
| X-RAY NUMBER | DATE OF X-RAY <i>5/3/02</i> | TECHNICIAN <i>Ben</i> | |
| <input type="checkbox"/> TREATMENT | <input type="checkbox"/> EXAMINATION | DETAILS: <i>Obst Series</i> | |
| REPORT | | PHYSICIAN <i>J.C. KORSZNAK, PA-C</i> | |
| <p>OBSTRUCTION SERIES- Radiographs of the abdomen demonstrate moderate constipation. There is no evidence of intestinal obstruction, significant ileus or free air. There are no definite renal or ureteral calculi. There is no active disease in the chest.</p> <p>IMPRESSION- Moderate constipation.</p> <p>PETER G. GREGORY, M.D. 05-08-02 lag</p> <p>DATE OF REPORT</p> | | | |

RECEIVED
MAY 10 2002
MEDICAL RECORDS DEPT.
SCI GRATERFORD

White—MEDICAL RECORD Canary—X-RAY FILE Pink—RADIOLOGIST FILE

| | | | |
|--|----------------|---|---------|
| DC-456 | | SCI-GRATERFORD | |
| X-RAY REPORT | | COMMONWEALTH OF PENNSYLVANIA DEPARTMENT OF CORRECTIONS | |
| NAME | Peay, Stratton | NUMBER | DP 4246 |
| X-RAY NUMBER | | DATE OF X-RAY | 11/9/01 |
| RECEIVED | | TECHNICIAN | |
| NOV 26 2001 | | DETAILS: | |
| MEDICAL RECORDS DEPT. SCI GRATERFORD | | Obstruction series to MO Constipation / Abdomen. Hx of GSW to abdomen | |
| REPORT | | J.C. KORSZNAK, PA. PHYSICIAN | |
| OBSTRUCTION SERIES- Radiographs of the abdomen demonstrate a normal intestinal gas pattern with no obstruction or free air. The bones are intact. Phleboliths are incidentally noted. There is a bullet overlying the left femoral head. | | | |
| PETER G. GREGORY, M.D. 11-13-01 lag | | Name: _____ Date / Time: 11-15-01 1500 A N NCS | |
| DATE OF REPORT | | RALPH W. SMITH, MD MEDICAL DOCTOR ROENTGENOLOGIST | |
| White—MEDICAL RECORD | | Canary—X-RAY FILE | |
| | | Pink—RADIOLOGIST FILE | |

| | | | |
|--|----------------|---|---------|
| DC-456 | | SCI-GRATERFORD | |
| X-RAY REPORT | | COMMONWEALTH OF PENNSYLVANIA DEPARTMENT OF CORRECTIONS | |
| NAME | Peay, Stratton | NUMBER | DP 4246 |
| X-RAY NUMBER | | DATE OF X-RAY | 8/24/01 |
| RECEIVED | | TECHNICIAN | |
| SEP 06 2001 | | DETAILS: | |
| MEDICAL RECORDS DEPT. SCI GRATERFORD | | Flat Plate & Erect 100 pen d/p GSW | |
| REPORT | | DENNIS IACCARINO, D.O. PHS PHYSICIAN | |
| ABDOMEN- Radiographs of the abdomen demonstrate moderate constipation. There is no evidence of intestinal obstruction or free air. The bones are grossly intact. | | | |
| IMPRESSION- Moderate constipation. A bullet is incidentally noted overlying the left hip. | | | |
| PETER G. GREGORY, M.D. 08-27-01 lag | | Name: _____ Date / Time: 8/30/01 1600 A N NCS | |
| DATE OF REPORT | | RALPH W. SMITH, MD MEDICAL DOCTOR ROENTGENOLOGIST | |
| White—MEDICAL RECORD | | Canary—X-RAY FILE | |
| | | Pink—RADIOLOGIST FILE | |

| | | | |
|---|--|--|------------|
| DC-456 | | COMMONWEALTH OF PENNSYLVANIA DEPARTMENT OF CORRECTIONS | |
| X-RAY REPORT | | | |
| NAME | | NUMBER | QUARTERS |
| X-RAY NUMBER | | DATE OF X-RAY | TECHNICIAN |
| <input type="checkbox"/> TREATMENT <input checked="" type="checkbox"/> EXAMINATION JUN 15 2001 MEDICAL RECORDS DEPT. SCI GRATERFORD | | DETAILS: Sacrum / coccyx - PC / full *old trauma also PHYSICIAN | |
| REPORT SACRUM AND COCCYX- The sacrum and coccyx are intact. There is a bullet projecting over the left femoral head region. There is somewhat increased density of the left femoral head but this is most likely unrelated to the presence of the bullet. Clinical correlation would be important. | | | |
| Diagnostic Reports ROMAS DOVYDAITIS, Name: <u>Mick</u> 06-11-01 lag Date / Time: <u>6-15-01 1600</u> (A) N NCS DATE OF REPORT ROENTGENOLOGIST | | | |
| White—MEDICAL RECORD | | Canary—X-RAY FILE | |

| | | | |
|--|--|---|------------|
| DC-456 | | COMMONWEALTH OF PENNSYLVANIA DEPARTMENT OF CORRECTIONS | |
| X-RAY REPORT | | | |
| NAME | | NUMBER | QUARTERS |
| X-RAY NUMBER | | DATE OF X-RAY | TECHNICIAN |
| <input type="checkbox"/> TREATMENT <input checked="" type="checkbox"/> EXAMINATION JUL 10 2001 MEDICAL RECORDS DEPT. SCI GRATERFORD | | DETAILS: PGI - pain - PHYSICIAN | |
| REPORT UPPER GI- Single contrast Upper GI study performed without flouroscopy demonstrates the esophagus, stomach, duodenal bulb and proximal small bowel to be grossly normal. There is no evidence of obstruction, mass lesion or peptic ulcer disease. | | | |
| Diagnostic Reports IMPRESSION- Grossly normal examination PETER G. GREGORY, M.D. 07-05-01 lag DATE OF REPORT Name: <u>RALPH W SMITH MD</u> Date / Time: <u>7-9-01</u> A NCS ROENTGENOLOGIST | | | |
| White—MEDICAL RECORD | | Canary—X-RAY FILE | |

| | | | | | |
|--|--|---|--|--|--|
| DC-456 | | SCI-GRATERFORD | | COMMONWEALTH OF PENNSYLVANIA DEPARTMENT OF CORRECTIONS | |
| X-RAY REPORT | | | | | |
| NAME <i>Peay, Stratton</i> | | NUMBER <i>DP4246</i> | | QUARTERS <i>13</i> | |
| X-RAY NUMBER | | DATE OF X-RAY <i>4/29/99</i> | | TECHNICIAN <i>[Signature]</i> | |
| <input type="checkbox"/> TREATMENT | | <input checked="" type="checkbox"/> EXAMINATION | | DETAILS: | |
| <i>*feels sick</i> | | <i>Flat Abdomen. X Ray</i> | | <i>abdominal pain x24⁰</i> | |
| | | | | Miguel Salomon, M.D. CPS Physician <i>[Signature]</i> PHYSICIAN | |
| REPORT ABDOMEN - There is a mild ileus gas pattern particularly in the right hemi abdomen, with no obstruction or free air. No significant calculi are seen. There is a bullet overlying the left femoral head. | | | | | |
| Peter G. Gregory, M.D. 05/03/99 wls | | | | | |
| Name: <i>[Signature]</i> Date/Time: <i>[Signature]</i> Requires a DC 472 SOAP Note | | | | | |
| DATE OF REPORT | | NCS | | ROENTGENOLOGIST <i>[Signature]</i> | |
| White—MEDICAL RECORD | | Canary—X-RAY FILE | | Pink—RADIOLOGIST FILE | |

| | | | | | |
|--|--|--------------------------------------|--|---|--|
| DC-456 | | SCI-GRATERFORD | | COMMONWEALTH OF PENNSYLVANIA DEPARTMENT OF CORRECTIONS | |
| X-RAY REPORT | | | | | |
| NAME <i>Peay, Stratton</i> | | NUMBER <i>DP4246</i> | | QUARTERS <i>D</i> | |
| X-RAY NUMBER | | DATE OF X-RAY <i>6/4/01</i> | | TECHNICIAN <i>[Signature]</i> | |
| <input type="checkbox"/> TREATMENT | | <input type="checkbox"/> EXAMINATION | | DETAILS: | |
| <i>RECEIVED JUN 12 2001 MEDICAL DEPT. SCI-GRATERFORD</i> | | <i>Tail bone xray</i> | | <i>AP and lateral view.</i> | |
| | | | | PHYSICIAN <i>[Signature]</i> | |
| REPORT COCCYX- Radiographs of the coccyx demonstrates no definite fracture or deformity. The visualized bones are intact and alignment of the sacral and coccygeal segment is grossly satisfactory. | | | | | |
| PETER G. GREGORY, M.D. 06-06-01 lag | | | | | |
| DATE OF REPORT | | NCS | | ROENTGENOLOGIST <i>[Signature]</i> | |
| White—MEDICAL RECORD | | Canary—X-RAY FILE | | Pink—RADIOLOGIST FILE | |

X-RAY REPORT

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF CORRECTIONS

NAME

Ray, Stratton

NUMBER

DP-4246

QUARTERS

X-RAY NUMBER

DATE OF X-RAY

4/27/98

TECHNICIAN

☐ TREATMENT☒ EXAMINATION

DETAILS:

APR 30 1998

MEDICAL DEPARTMENT
SCI GRATERFORD

CPL

L

PHYSICIAN

REPORT

CHEST - EXAMINATION OF THE CHEST REVEALS CARDIO MEDIASTINAL SILHOUETTE NORMAL. LUNG FIELDS ARE CLEAR. DIAPHRAGMS AND COSTOPHRENIC ANGLES SHARP. BONEY STRUCTURES ARE NORMAL.

IMPRESSION: NORMAL CHEST - NO ACTIVE DISEASE.

DOUGLAS W. PARRILLO, M.D.
04/28/98 WLS

Dr Peter Baddick, D.O.

Diagnostic Reports

Name:

Date:

A

N

MCS

A-Requires a DC 472 SOAP Note

DATE OF REPORT

KAREN PANCZAK, RN II
TB NURSE

ROENTGENOLOGIST

White-MEDICAL RECORD

Canary-X-RAY FILE

Pink-RADIOLOGIST FILE

DC-456

X-RAY REPORT

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF CORRECTIONS

NAME

Ray

NUMBER

DP 4246

QUARTERS

E

X-RAY NUMBER

DATE OF X-RAY

12-24-98

TECHNICIAN

☐ TREATMENT☒ EXAMINATION

DETAILS:

no trauma

X Ray of Sacral area.
line on sacrum

Salomon

RECEIVED

DEC 31 1998

PHYSICIAN

REPORT

SACRUM - Frontal and lateral radiographs of the sacrum demonstrates a bullet overlying the left hip which is seen to be anterior on the lateral radiograph. The bones are intact with no evidence of fracture, deformity or bone destruction.

IMPRESSION: Unremarkable sacrum. A bullet over the left hip is again noted anteriorly.

Peter G. Gregory, M.D.
DATE OF REPORT WLS

Name:

Date:

A

Peter Baddick, D.O.
Medical Director

ROENTGENOLOGIST

White-MEDICAL RECORD

A-Requires a DC 472 SOAP Note

Pink-RADIOLOGIST FILE

PHYSICAL EXAMINATION

| | | | | | |
|---|---------------|---------------------------|--------------------|---|----------------|
| Exam Date: <u>9/2/02</u> | | Exam Time: <u>9:00 PM</u> | | Type of Examination: _____ Initial: _____ Annual: _____ | |
| | | | | Parole Violator: _____ Biennial: _____ Other: _____ | |
| Age: <u>25</u> | Sex: <u>M</u> | Height: <u>5'8"</u> | Weight: <u>177</u> | Pulse: _____ | BP: _____ |
| Next of Kin: <u>ETHA PEAY</u> | | | | Phone Number: <u>215 879-6277</u> | |
| Address: <u>1740 N. Wilson St. Phila Pa 19137</u> | | | | <u>MOTHER</u> | |
| Allergies/Drug Sensitivities: <u>NKDA</u> | | | | | |
| Audiogram: | | | Visual Acuity: | | |
| Right: | Normal | Abnormal | Right: | Uncorrected / | Corrected To / |
| Left: | Normal | Abnormal | Left: | Uncorrected / | Corrected To / |

Laboratory Tests (check if completed)

| check | | check | | check | | check | |
|-------|-----------------------|-------|-----------|-------|-------------|-------|-------------------|
| | CBC with Differential | | STS | | Chest X-Ray | | Electrocardiogram |
| | Chemistry Profile | | PPD | | PAP Smear | | Mammogram |
| | Urinalysis | | Hemoccult | | Other: | | |

Signature of Nurse Completing Top Portion:

| |
|------------------|
| Signature: _____ |
|------------------|

Physical Examination

| | Normal | Abnormal | Abnormal Findings — Enter item number and describe in detail. Use reverse side if necessary |
|----------------------------|--------------|----------|---|
| 1. Head, Face, Neck, Scalp | ↓ | | <p>— Old leg ulcers</p> |
| 2. Noses/Sinuses | | | |
| 3. Mouth and Throat | | | |
| 4. Teeth | | | |
| 5. Ears | ↓ | | |
| 6. Eyes/Pupils | | | |
| 7. Fundoscopy | NOT ASSESSED | | |
| 8. Lungs and Chest | | | |
| 9. Heart | ↓ | | |
| 10. Vascular System | | | |
| 11. Abdomen | | | |
| 12. Anus & Rectum | NOT ASSESSED | | |
| 13. Prostate | | | |
| 14. Endocrine System | | | |
| 15. Genitalia | | | |
| 16. Extremities | | | |
| 17. Lymph Nodes | | | |
| 18. Feet | ↓ | | |
| 19. Musculoskeletal | | | |
| 20. Skin | | | |
| 21. Neurologic | | | |
| 22. Mental Status | NOT ASSESSED | | |
| 22. Other | | | |

Physical Examination
Commonwealth of Pennsylvania
Department of Corrections
DC-440

Revised 10/00

Inmate Name: Peay
Inmate Number: DP4246
DOB: 11-4-76
Facility: SP1A

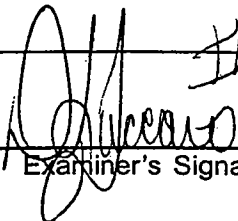
PHYSICAL EXAMINATION — CONTINUED

| | Normal | Abnormal |
|-----------------|--------|----------|
| 24. Female Only | | |
| a. Breast | | |
| b. Vagina | | |
| c. Cervix | | |
| d. Uterus | | |
| e. Adnexa | | |

Abnormal Findings — Enter item number and describe in detail.

Remarks (Recommendations or referrals, treatment plan, etc.)

Chromosomes
Psych Disturbance

 INCUBATED
9/17/02 4:00pm
Examiner's Signature Date/Time

The Medical Clearance Form is also to be completed.

PHYSICAL EXAMINATION

| | | | | | | | |
|--|--|------------------------|---------------------|--------------------------------------|-----------------------------------|-----------------------|----------------------|
| Exam Date: <u>4/17/00</u> | | Exam Time: <u>1000</u> | | Type of Examination: Parole Violator | | Initial <u> </u> | Annual <u> </u> |
| Age: <u>23</u> | | Sex: <u>M</u> | Height: <u>5'8"</u> | Weight: <u>177</u> | Pulse: <u>72</u> | BP: <u>130/80</u> | Temp: <u> </u> |
| Next of kin: <u>Etta Peay (Mother)</u> | | | | | Phone number: <u>215-879-6277</u> | | |
| Address: <u>1740 N. Wilton ST. Phila 19131</u> | | | | | | | |
| Audiogram | | | | Visual Acuity | | | |
| Right: Normal | | Abnormal | | Right: Uncorrected <u>20 120</u> | | Corrected to <u>1</u> | |
| See Audiogram Testing | | | | | | | |
| Left: Normal | | Abnormal | | Left: Uncorrected <u>20 120</u> | | Corrected to <u>1</u> | |

LABORATORY TESTS (check if completed)

| | | | | | | | |
|-------|-----------------------|-------|-----------|-------|-------------|-------|-------------------|
| check | | check | | check | | check | |
| | CBC with Differential | | STS | | Chest X-Ray | | Electrocardiogram |
| | Chemistry Profile | | PPD | | PAP Smear | | Mammogram |
| | Urinalysis | | Hemoccult | | Other: | | |

PHYSICAL EXAMINATION

| | Normal | Abnormal | Abnormal Findings - Enter item number and describe in detail. Use reverse side if necessary |
|----------------------------|-----------|----------|--|
| 1. Head, Face, Neck, Scalp | / | | |
| 2. Nose/Sinuses | / | | |
| 3. Mouth and Throat | / | | |
| 4. Teeth | / | | |
| 5. Ears | / | | |
| 6. Eyes/Pupils | / | | |
| 7. Fundoscopy | / | | |
| 8. Lungs and Chest | / | | |
| 9. Heart | / | | |
| 10. Vascular System | / | | |
| 11. Abdomen | / | | |
| 12. Anus and Rectum | / | | |
| 13. Prostate | / | | |
| 14. Endocrine System | / | | |
| 15. Genitalia | / | | |
| 16. Extremities | / | | |
| 17. Lymph Nodes | / | | |
| 18. Feet | / | | |
| 19. Musculoskeletal | / | | |
| 20. Skin | / | | |
| 21. Neurologic | / | | |
| 22. Mental Status | / | | |
| 23. Other | <u>NP</u> | | |

midline surgical scar

UNDER 50 PHYSICAL

Physical Examination
Commonwealth of Pennsylvania
Department of Corrections
DC-440

Inmate Name: Peay, Stratton
Inmate Number: DP 4246
DOB: 11/4/76
Institution: SCI/GRATERFORD

PHYSICAL EXAMINATION - CONTINUED

| | Normal | Abnormal |
|----------------|--------|----------|
| 4. Female Only | | |
| a. Breast | | |
| b. Vagina | | |
| c. Cervix | | |
| d. Uterus | | |
| e. Adnexa | | |

Abnormal Findings - Enter item number and describe in detail.

① no acute process

Remarks (Recommendations or referrals, treatment plan, etc.)

Examiner's Signature

Date/Time

J.C. Korszniak, PA-C

The Medical Clearance Form is also to be completed.

MEDICAL CLEARANCE FORM**TYPE**

- ☐ Initial Classification ☐ Annual Physical ☐ Revision due to change in Health Status
☐ Parole Violator, CCC returns, returned escapees, ATA, HVA, with more than six months absence ☒ Biennial Physical ☐ Boot Camp Clearance

FOOD SERVICE

- ☒ Is approved for food service. ☐ Is **not** approved for food service.

MEDICAL CLEARANCE (Please Check as appropriate:)

Is medically cleared without limitations for: ☒ Regular Housing ☒ Employment ☒ Activities ☐ Boot Camp

Is medically cleared with the following limitations:

Housing: _____

Employment: _____

Activities: _____

Other: _____

Is not medically cleared for: ☐ Regular Housing ☐ Employment ☐ Activities ☒ Boot Camp

Signature

Date/Time

Korszniak, PA-C

WHITE - Medical Records

CANARY - Inmate Employment Office

PINK - Activities

Medical Clearance Form
 Commonwealth of Pennsylvania
 Department of Corrections
 DC - 480

Inmate Name:

Peay, Stratton

Inmate Number:

DP 4246

DOB:

11/4/76

Institution:

SCIG

BP
 4/25/00
 1255

PHYSICAL EXAMINATION

| | | | | | | | |
|---|---------------|-------------------------|--------------------|---|-------------------------------------|--|---|
| Exam Date: <u>5/18/98</u> 18 MAY 1998 | | Exam Time: <u>1133</u> | | Type of Examination: <u>Parole Violator</u> | | Initial <u> </u> Annual <u> </u> Biennial <u> </u> Other <u> </u> | |
| Age: <u>21</u> | Sex: <u>m</u> | Height: <u>5'9 1/2"</u> | Weight: <u>172</u> | Pulse: <u>64</u> | BP: <u>100/66</u> | Temp: <u>99.2</u> | |
| Next of kin: <u>ETTA CONOVER (MOM)</u> | | | | | Phone number: <u>(215) 879-6277</u> | | |
| Address: <u>1740 W. WILLOW ST</u> | | | | | | | |
| Audiogram | | SEE AUDIOGRAM | | Visual Acuity | | SEE TELEBINOCULAR | |
| Right: | Normal | Abnormal | | Right: | Uncorrected | Corrected to | / |
| Left: | Normal | Abnormal | TESTING | Left: | Uncorrected | Corrected to | / |

LABORATORY TESTS (check if completed)

| | | | | | | | |
|-------------------------------------|-----------------------|-------------------------------------|------------|-------------------------------------|-----------------|-------|-------------------|
| check | | check | | check | | check | |
| <input checked="" type="checkbox"/> | CBC with Differential | <input checked="" type="checkbox"/> | STS | <input checked="" type="checkbox"/> | Chest X-Ray WAO | | Electrocardiogram |
| <input checked="" type="checkbox"/> | Chemistry Profile | <input checked="" type="checkbox"/> | PPD 0 0 mm | | PAP Smear | | Mammogram |
| <input checked="" type="checkbox"/> | Urinalysis | | Hemocult | | Other: | | |

PHYSICAL EXAMINATION

| | Normal | Abnormal |
|----------------------------|--------|----------|
| 1. Head, Face, Neck, Scalp | | |
| 2. Nose/Sinuses | | |
| 3. Mouth and Throat | | |
| 4. Teeth | | |
| 5. Ears | | |
| 6. Eyes/Pupils | | |
| 7. Fundoscopy | | |
| 8. Lungs and Chest | | |
| 9. Heart | | |
| 10. Vascular System | | |
| 11. Abdomen | | |
| 12. Anus and Rectum | | |
| 13. Prostate | | |
| 14. Endocrine System | | |
| 15. Genitalia | | |
| 16. Extremities | | |
| 17. Lymph Nodes | | |
| 18. Feet | | |
| 19. Musculoskeletal | | |
| 20. Skin | | |
| 21. Neurologic | | |
| 22. Mental Status | | |
| 23. Other | | |

Abnormal Findings - Enter item number and describe in detail.
Use reverse side if necessary

#11 knee @ up @ hospital

5 yr insulin old

TAPPO @ upper arm @ day

Physical Examination
Commonwealth of Pennsylvania
Department of Corrections
DC-440

Inmate Name: Peay, Stratton

Inmate Number: DP4246

DOB: 11/4/76

Institution: SCI Camp Hill

PHYSICAL EXAMINATION - CONTINUED

| | Normal | Abnormal |
|-----------------|--------|----------|
| 24. Female Only | | |
| a. Breast | | |
| b. Vagina | | |
| c. Cervix | | |
| d. Uterus | | |
| e. Adnexa | | |

Abnormal Findings - Enter item number and describe in detail.

S/A abd exploratory 2nd GSW
 ⊖ negative.

Remarks (Recommendations or referrals, treatment plan, etc.)

Medically Cleared for Transfer

PHIL RICHARDSON, PA-C
 PHYSICIAN ASSISTANT - WHS

12 May 1999

 Examiner's Signature

 Date/Time

The Medical Clearance Form is also to be completed.

INPATIENT UNIT SUMMARY

| | |
|---|---|
| To be completed upon admission: | |
| Date of Admission: | 9-20-02 |
| Provisional Diagnosis: | S.I. |
| Allergies: | NKDA |
| Name and Address of Next of Kin: | ETTA PEAY 1740 N. WILSON ST. PHILA, PA 19131 |
| Relationship: | MOTHER |
| Phone Number: | 215 879-6277 |
| To be completed upon discharge: | |
| Date of Discharge: | 9/23/02 |
| Discharge Diagnosis: | 8/A adu. |
| Chief Complaint and History: | Stomach pain "... I have most likely colon cancer" |
| Procedures/Operations performed during admission: | POC 1:1 |
| (Summary continues on reverse side) | |

Inpatient Unit Summary
Commonwealth of Pennsylvania
Department of Corrections
DC - 474

Inmate Name: PEAY
Inmate Number: DP 4246
DOB: 11-4-76
Institution: SCIA

| INPATIENT UNIT NURSING CARE PLAN | | | | |
|--|---|--|--|-----------------------|
| Admission Date <u>9/20/02</u> Discharge Date <u>S.I.</u> | | Diagnosis <u>S.I.</u> | | |
| Please remember that each entry must be signed. | | | | |
| DATE | PROBLEM OR NURSING DIAGNOSIS | NURSING INTERVENTION | OBJECTIVE AND/OR EXPECTED OUTCOME | DATE RESOLVED/CHANGED |
| 9/20/02 | <p>Attenuation thought processes</p> <p>Potential for self harm</p> | <p>Provide safe environment</p> <p>1:1 watch hard cell</p> <p>medicate per drs orders</p> <p>encourage verbalization</p> <p>stressors</p> <p>encourage food & fluids</p> | Inmate will remain free of harm while in the infirmary | |

Inmate Name: Peay StrahanInmate Number: DP4246DOB: 11-4-76Institution: Sci9

Inpatient Unit Nursing Care Plan
 Commonwealth of Pennsylvania
 Department of Corrections
 DC-478

| MO./DAY/YR. | | 9/20/02 | | 9/21/02 | | 9/23/02 | | 9/24/02 | | 9/25/02 | | 9/26/02 | | 9/27/02 | |
|------------------------|-----|---------|------|---------|------|---------|------|---------|------|---------|------|---------|------|---------|------|
| | | A.M. | P.M. | A.M. | P.M. | A.M. | P.M. | A.M. | P.M. | A.M. | P.M. | A.M. | P.M. | A.M. | P.M. |
| HOUR | | | | | | | | | | | | | | | |
| Pulse (Circle) | 150 | | | | | | | | | | | | | | |
| | 140 | | | | | | | | | | | | | | |
| | 130 | | | | | | | | | | | | | | |
| | 120 | | | | | | | | | | | | | | |
| | 110 | | | | | | | | | | | | | | |
| | 100 | | | | | | | | | | | | | | |
| | 90 | | | | | | | | | | | | | | |
| | 80 | | | | | | | | | | | | | | |
| | 70 | | | | | | | | | | | | | | |
| | 60 | | | | | | | | | | | | | | |
| Temperature (Triangle) | 106 | | | | | | | | | | | | | | |
| | 105 | | | | | | | | | | | | | | |
| | 104 | | | | | | | | | | | | | | |
| | 103 | | | | | | | | | | | | | | |
| | 102 | | | | | | | | | | | | | | |
| | 101 | | | | | | | | | | | | | | |
| | 100 | | | | | | | | | | | | | | |
| | 99 | | | | | | | | | | | | | | |
| | 98 | | | | | | | | | | | | | | |
| | 97 | | | | | | | | | | | | | | |
| 96 | | | | | | | | | | | | | | | |
| Respirations | | | | | | | | | | | | | | | |
| Blood Pressure | | | | | | | | | | | | | | | |
| Weight | | | | | | | | | | | | | | | |
| Intake | | | | | | | | | | | | | | | |
| Output | | | | | | | | | | | | | | | |
| Initials | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | |

Inpatient Vital Signs Flow Sheet
Commonwealth of Pennsylvania
Department of Corrections
DC-475

Inmate Name: Peay, Stratton
Inmate Number: DP4246
DOB: 11-4-76
Institution: SCLG

INPATIENT UNIT SUMMARY

To be completed upon admission:

Date of Admission:

SI 8.20.02

Provisional Diagnosis:

SI

Allergies:

NKA

Name and Address of Next of Kin:

Etha Gray
1740 R. Milton St.

Relationship:

mother

Phone Number:

215-879-6277

To be completed upon discharge:

Date of Discharge:

08/21/02

Discharge Diagnosis:

Chief Complaint and History:

None

Procedures/Operations performed during admission:

1:1 Interview

(Summary continues on reverse side)

Inpatient Unit Summary
Commonwealth of Pennsylvania
Department of Corrections
DC - 474

Inmate Name:

PEAT, S

Inmate Number:

DP 4246

DOB:

11.4.76

Institution:

SCI-C

INPATIENT UNIT NURSING CARE PLAN

Admission Date 8-20-02 Discharge Date 5-4
 Please remember that each entry must be signed.

| DATE | PROBLEM OR NURSING DIAGNOSIS | NURSING INTERVENTION | OBJECTIVE AND/OR EXPECTED OUTCOME | DATE RESOLVED/CHANGED |
|---------|------------------------------|--|-----------------------------------|-----------------------|
| 8-20-02 | ↑ Risk Self Harm | <ol style="list-style-type: none"> 1- Poc, 1:1 2- All suicide precautions, finger foods 3- Assess Q 4th for Agitation/ ANXIETY 4- Quiet / Therapeutic Environment 5- Therapeutic Listening 6- Plu = Prolong | | |

Inpatient Unit Nursing Care Plan
 Commonwealth of Pennsylvania
 Department of Corrections
 DC-478

Inmate Name:

Leah, S

Inmate Number:

DP 42-46

DOB:

11-4-76

Institution:

SCI-6

| MO./DAY/YR. | | | | | | | | | | | | | | | | |
|----------------|----------------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|--|
| | | A.M. | P.M. | A.M. | P.M. | A.M. | P.M. | A.M. | P.M. | A.M. | P.M. | A.M. | P.M. | A.M. | P.M. | |
| HOUR | | | | | | | | | | | | | | | | |
| Pulse (Circle) | 150 | | | | | | | | | | | | | | | |
| | 140 | | | | | | | | | | | | | | | |
| | 130 | | | | | | | | | | | | | | | |
| | 120 | | | | | | | | | | | | | | | |
| | 110 | | | | | | | | | | | | | | | |
| | 100 | | | | | | | | | | | | | | | |
| | 90 | | | | | | | | | | | | | | | |
| | 80 | | | | | | | | | | | | | | | |
| | 70 | | | | | | | | | | | | | | | |
| | 60 | | | | | | | | | | | | | | | |
| | 50 | | | | | | | | | | | | | | | |
| | 40 | | | | | | | | | | | | | | | |
| | 30 | | | | | | | | | | | | | | | |
| | Respirations | | | | | | | | | | | | | | | |
| | Blood Pressure | | | | | | | | | | | | | | | |
| | Weight | | | | | | | | | | | | | | | |
| Intake | | | | | | | | | | | | | | | | |
| Output | | | | | | | | | | | | | | | | |
| Initials | | AM | | | | | | | | | | | | | | |
| | | PM | | | | | | | | | | | | | | |

Inpatient Vital Signs Flow Sheet
Commonwealth of Pennsylvania
Department of Corrections
DC-475

Inmate Name:

Peaf, S

Inmate Number:

DP4 246

DOB:

11-4-76

Institution:

Sci-G

INPATIENT UNIT SUMMARY

| | |
|---|---|
| To be completed upon admission: | |
| Date of Admission: | 07/15/02 |
| Provisional Diagnosis: | Psychiatric |
| Allergies: | |
| Name and Address of Next of Kin: | Etta Peay (mother) 1740 N. Wilton St. Phila., Pa. 19131 |
| Relationship: | Phone Number: 215-879-6277 |
| To be completed upon discharge: | |
| Date of Discharge: | 07/16/02 |
| Discharge Diagnosis: | None V71.09 |
| Chief Complaint and History: | Pt stated he was suicidal because he wanted medical treatment. Claimed no bowel movement x 2 wks. |
| Procedures/Operations performed during admission: | as per medical |
| (Summary continues on reverse side) | |

Inpatient Unit Summary
Commonwealth of Pennsylvania
Department of Corrections
DC - 474

Inmate Name: PEAY
Inmate Number: DP 4246
DOB:
Institution: SCI GRA

INPATIENT UNIT NURSING CARE PLAN

Admission Date _____ Discharge Date _____ Diagnosis _____

Please remember that each entry must be signed.

| DATE | PROBLEM OR NURSING DIAGNOSIS | NURSING INTERVENTION | OBJECTIVE AND/OR EXPECTED OUTCOME | DATE RESOLVED/ CHANGED |
|---------|------------------------------|---|-----------------------------------|------------------------|
| 7/15/02 | Suicidal Ideation | 1. Placed in safe environment 2. Strip cell, suicide vest and blanket, no mattress 3. Hunger for food 4. 1:1 watch by security | Stability | |

Inpatient Unit Nursing Care Plan
 Commonwealth of Pennsylvania
 Department of Corrections
 DC-478

Inmate Name: PEAY
 Inmate Number: DP 4246
 DOB:
 Institution: SCI GRA

INPATIENT UNIT SUMMARY

To be completed upon admission:

Date of Admission: 6-24-02

Provisional Diagnosis: S.I.

Allergies: NKDA

Name and Address of Next of Kin:

ETTA Peay
1740 N. Wilton St.

Relationship: Mo

Phil 19131

Phone Number: 315-879-6270

To be completed upon discharge:

Date of Discharge: 6/25/02

Discharge Diagnosis: S/A

Chief Complaint and History:

None

Procedures/Operations performed during admission:

pdc 1:1 Infirmary

(Summary continues on reverse side)

Inpatient Unit Summary
Commonwealth of Pennsylvania
Department of Corrections
DC - 474

Inmate Name:

Peay, S

Inmate Number:

DP 4246

DOB:

11-4-76

Institution:


SciG

DC14-RECEPTION PSYCHIATRIC/PSYCHOLOGICAL QUESTIONNAIRE/REFERRAL

DC# DP4246 NAME Peggy Stratton DATE 5/6/98 TIME 1215

1. Do you have any history of mental illness ? NO
2. Have you ever been treated for a nervous condition ? NO
3. Have you ever been examined or questioned by a psychologist or psychiatrist ? NO
4. Have you ever been hospitalized for a mental illness ? If yes, specify General or Mental Health Hospital. NO
5. Are you currently on any psychotropic or nerve medications ? If yes, list meds. NO
6. Have you taken psychotropic or nerve medications in the past ? If yes, list meds. NO
7. Have you ever attempted suicide, self-harm or self-mutilation ? NO

RECOMMENDATION/ REFERRAL: _____


Signature of Medical or Psychology Staff Completing Form

(White)--Medical Record

(Canary)-CDCC Psychology

(Pink)- Medical/Control Bubble

INDIVIDUAL TREATMENT PLAN

| | | | |
|---|----------------------|--|---------------------------------------|
| (1) Name <i>S. Peay</i> | | (2) DC# <i>DP-4246</i> | (3) Assigned PSA <i>B. Ladonne</i> |
| (4) ICD Code <i>NONE</i> | (5) GAF <i>30</i> | (6) Assigned Psychiatrist <i>Dr. Kiyabony</i> | |
| (7) Date of Last Treatment Plan Review | | | |
| (8) Problems & Goals (Minimum of 2) | | (9) Treatment Objectives (Observable & Measurable) | |
| <i>No indications of psychiatric/psychological problems. Denies any emotional problems & said he was suicidal to RTH guards to get to INMAY to discuss medical problems</i> | | <i>Cleared for discharge from psychiatry must be cleared by medical.</i> | |
| | | (10) Objectives Target Date | |
| | | <i>NONE</i> | |
| Treatment Modalities Check All That Apply | | Projected Frequency & Duration of Treatment | |
| | | Once/wk | Twice/wk |
| | | Every 2 Weeks | Once/Mo. |
| (12) Individual | | | |
| (13) Group | | | |
| (14) Employment | | | |
| (15) Education | | | |
| (16) Other (Specify) | | | |
| | | (11) Anticipated Length of Treatment | |
| | | Up to 3 Mos. _____ | |
| | | Up to 6 Mos. _____ | |
| | | More than 1 Year _____ | |

Review/Updates

Review and Update Treatment Plan on a new form as follows:

1. Initial Review (to be completed within 14 days of admission).
2. SNU reviews a minimum of one every 120 days.
3. At the request of the Unit Manager.

RECEIVED

JUN 27 2002

MEDICAL RECORDS DEPT.
SCI GRATERFORD

(17) Client Signature/Date

(19) Counselor Signature

Date

(18) Psychology Staff/Date
Signature

(20) Psychiatrist Signature/Date

(21) Unit Manager Signature/Date

INMATE NAME: PeayDOC #: DP 9296RHU Officer completing form (print): LT. I. SOLERDate: 6-3-02 Time: 1200

1. Escorting officer has information that inmate may be a suicidal risk.
2. Inmate is expressing suicidal thoughts / making threats to harm self.
3. Inmate shows signs of depression (crying, withdrawn, passive). stressed
4. Inmate is acting / talking in a strange manner (hearing / seeing things that aren't there).
5. Inmate appears to be under the influence of drugs / alcohol.
6. Inmate has recent family change (e.g., death of child/spouse/parent or "Dear John Letter").
7. Inmate has recent legal status change (e.g., parole violation or new detainee).
8. Inmate has been assaulted (physically or sexually) by another inmate.
9. Inmate shows anger, hostility, and threats.
10. Inmate appears anxious, afraid (pacing, wringing hands).
11. Inmate displays signs of self-neglect or abuse (e.g., poor hygiene or cuts and bruises).
12. Inmate states this is his / her first placement in RHU.
13. Inmate states that he / she is taking psychiatric medication.

Comments:

Instructions: The ranking CO present shall ensure that this form is completed when an inmate is brought to the RHU. The escorting officer will be asked (a) why the inmate is being brought in and (b) whether there is any information that the inmate may be self-destructive. The inmate will be asked (a) if this is his / her first time in the RHU, (b) if he / she has any special problems or needs of which staff should be aware, (c) if he / she is on any medication, and/or (d) whether he / she has any recent legal status changes (e.g., Parole violation, detainees). The officer will also note any special physical / behavioral characteristics (e.g., crying, poor hygiene, cuts & bruises) or if the inmate is uncooperative.

If any of items #1 through #7 are checked "Yes", the RHU officer shall immediately phone the following staff:

- Between 8:00 a.m. and 4:30 p.m., nursing and Chief Psychologist or MHC. Psychologist will immediately visit the RHU and review the checklist, assess the inmate, and discuss the case with RHU staff. Time of assessment will be recorded on form.
- After hours, or on weekends, the nursing staff and Shift Commander. Nurse will immediately visit RHU to review the checklist, assess the inmate, and discuss case with RHU staff. Time of assessment will be recorded on form.
- At any time the inmate appears in immediate danger of harming him / herself or somebody else, the RHU staff shall also contact the Shift Commander, as well as nursing staff and Chief Psychologist or MHC to request an immediate assessment.

If any of items #8 through #13 are checked, the form will be submitted to the nurse and / or psychologist the next time the inmate visits the RHU, but within 24 hours. The nurse or psychologist will assess the inmate and note the date and time of assessment. The completed form will remain in the Cumulative Adjustment Record until reviewed by PRC. Copies to Medical Records and DC-14.

Clinical Staff Action: MR. Peay is denied of having MH problems and his concern is not getting enough medical treatment for his medical condition.

Date: 6/5/02 Time: 0940Name of Clinical staff (printed): C. Joseph Title: PSS

EDICATION ADMINISTRATION RECORD

DT01

August 2002

| INDICATIONS | HOUR | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 |
|-----------------------------|----------|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
| old set 6 I po T50 | 08 12 | ml | ml | ml | ml | ml | ml | ml | ml | ml | ml | ml | ml | ml | ml | ml | ml | ml | ml | ml | ml | ml | ml | ml | ml | ml | ml | ml | ml | ml | ml |
| 8/02 8/03/02 20 | 20 | sw | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| olace 100mg 7 po BID | 08 | ml | ml | ml | ml | ml | ml | ml | ml | ml | ml | ml | ml | ml | ml | ml | ml | ml | ml | ml | ml | ml | ml | ml | ml | ml | ml | ml | ml | ml | ml |
| 130/02 8/28/02 20 | 20 | sw | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Bentyl 20mg 7 po PRN TLD | 08 12 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 18/02 8/14/02 20 | 20 | sw | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

| INDICATIONS | HOUR | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 |
|-------------|------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
|-------------|------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|

NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE

| | | | |
|-----------------------|------------------|--------------------------|--------------------|
| ARTING FOR 08/01/02 | THROUGH 08/31/02 | Telephone No. | Medical Record No. |
| Physician PA Martinez | | Alt. Telephone | |
| Diagnosis | | Rehabilitative Potential | |

| | | | | |
|--------------|-----------------|---------------------------|--------------|-------------|
| icaid Number | Medicare Number | Complete Entries Checked: | Title: | Date: |
| | | By: | PATIENT CODE | ROOM NO. |
| | | | NP4246 | ✓ SAH |
| | | | | BED |
| | | | | FACILITY CC |
| | | | | QADT 19 |

PROGRESS NOTES

☐ Outpatient

☒ Inpatient

| Date/Time | Prob # | Discipline Abbreviation | Remarks Subjective, Objective, Assessment, Plan |
|-----------|--------|-------------------------|---|
| 9/23/02 | | 4 | PSYCHIATRIC OBSERVATION (CH). (S) "I HAVE a MEDICAL PROBLEM \pm MY BOWELS, ... I TOLD THEM I WAS SUICIDAL BECAUSE THEY ARE DENYING ME CARE." (O) MR PLAY PRESENTED AS SOMEWHAT PARANOID ("THE GUARDS ARE TRYING TO KILL ME; THEY'RE PUTTING STUFF IN MY FOOD, and are blowing HARMFUL GAS THROUGH THE VENTS...") and delusional (A) IT APPEARS THAT MR PLAY COULD BENEFIT FROM A REGIMEN of PSYCHOTROPIC MEDICATION (P) PSYCHIATRIST DISCHARGED INMATE TO L. BLOCK as he feels MR PLAY IS MANIPULATIVE. |
| | | | CONV. (S) DURING PMS |

Progress Notes
Commonwealth of Pennsylvania
Department of Corrections
DC-472

Inmate Name:

READY

Inmate Number:

#DP 4246

DOB:

Facility:

G/A

MEDICATION ADMINISTRATION RECORD

DT01

| EDICATIONS | HOUR | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 |
|---|------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
| ADM to P.O.C. F/U 4 Mon 120/02 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1:1 Security Watch 120/02 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Suicide Vest + blanket + Mattress on Floor 120/02 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| F/U 5 Medical re Multiple Somatic Complaints 120/02 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

| EDICATIONS | HOUR | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 |
|--|------|--|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
| ADM 9.20.02 ARTING FOR 9.03 Physician SMITH Physician Klyshorny argies gnosis SI icaid Number Medicare Number Complete Entries Checked: By: TENT P E A V C H | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE | | <div style="text-align: right;"> RECEIVED SEP 25 2002 DOB 11.4.76 MEDICAL RECORDS DEPT. SCI GRATERBORN </div> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Telephone No. | | Medical Record No. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Alt. Telephone | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Rehabilitative Potential | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Title: | | Date: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PATIENT CODE | | ROOM NO. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| BED | | FACILITY C | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

| EDUCATIONS | HOUR | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 |
|------------|------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
|------------|------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|

88

20

7/4

8280

Cold Set #1 T±0 p.

02/03/02 20

08

7/30/02 8/28/02 20

| INDICATIONS | HOUR | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 |
|-------------|------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
|-------------|------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|

NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE

THROUGH 07/31/12

Telephone No. _____

Medical Record No.

Alt. Telephone

Rehabilitative
Potential

| | | |
|--------------|-----------------|---------------------------|
| icaid Number | Medicare Number | Complete Entries Checked: |
|--------------|-----------------|---------------------------|

By:

Title:

Date:

AGENT Pen. Cotton

| | |
|---------|---------|
| PATIENT | DP 4246 |
|---------|---------|

ROOM IV

| | |
|-----|-------------|
| BED | FACILITY CO |
|-----|-------------|

MEDICATION ADMINISTRATION RECORD

DT01

| INDICATIONS | HOUR | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 |
|---|------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
| Admit to infirmary 8:15 min. watch | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1/20/02 Suicidal vest Suicidal blanket | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1/20/02 Finger food | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1/20/02 Risperdal 50mg IM 2 PO 94% PRN for agitation 8/20/02 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| E/U with psych. 7:11M 8/21/02 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 8/20/02 MAG CITRATE - 1/2 bottle PO + 1 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 11:02 AUTHORIZATION form to retrieve ED records from H.U.P. (L/M 11:02 ADmits To Handle used Alibis) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

REFUSED

8

PENDING

| INDICATIONS | HOUR | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | | | | | | | | | | |
|--|------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|--------------------------|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|--------------------|--|--|--|--|--|--|--|--|--|
| NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ARTING FOR | | | | | | | | | | | | | | | | THROUGH | | | | | | | | | | | | | | | | | | | | | | | | | |
| sician | | | | | | | | | | | | | | | | Telephone No. | | | | | | | | | | | | | | | | Medical Record No. | | | | | | | | | |
| Physician | | | | | | | | | | | | | | | | Alt. Telephone | | | | | | | | | | | | | | | | | | | | | | | | | |
| gies | | | | | | | | | | | | | | | | Rehabilitative Potential | | | | | | | | | | | | | | | | | | | | | | | | | |
| NKDA | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

| | | | | | | |
|------------|-----------------|---------------------------|--------------|----------|-------|---------------|
| aid Number | Medicare Number | Complete Entries Checked: | Title: | | Date: | |
| ENT | By: | | PATIENT CODE | ROOM NO. | BED | FACILITY CODE |
| | Pres. Stratten | | DP 4246 | 87 | | |

[illegible]

| INDICATIONS | HOUR | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 |
|-------------|------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
|-------------|------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|

NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE

STARTING FOR 8-3-02 THROUGH 8-31-02

| | | |
|---------------------|---------------|--------------------|
| sician <u>Smith</u> | Telephone No. | Medical Record No. |
|---------------------|---------------|--------------------|

| | |
|-----------|----------------|
| Physician | Alt. Telephone |
|-----------|----------------|

| | |
|--------------------------------|-------------------------------------|
| <p>gics</p> <p><i>NKDA</i></p> | <p>Rehabilitative Potential</p> |
|--------------------------------|-------------------------------------|

Diagnosis GI complaints

| | | |
|-------------|-----------------|---------------------------|
| Card Number | Medicare Number | Complete Entries Checked: |
|-------------|-----------------|---------------------------|

By: _____ Title: _____ Date: _____

| | | | | | |
|-----|-----------------|--------------|----------|-----|------------|
| ENT | Dr. J. Stratton | PATIENT CODE | ROOM NO. | BED | FACILITY C |
| | | DPW346 | 3023 | | SCIS |

EDICATION ADMINISTRATION RECORD

T01

| LOCATIONS | HOUR | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 |
|--|------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
| F/U in A.M. C counselor | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1/15/02 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Strip Cell suit vest and blanket, no mattress or pillow | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1/15/02 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| constant water | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1/15/02 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| finger food | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1/15/02 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Thorazine 50mg q 30 min PRN for agitation max 6x/24 hours | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1/15/02 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

| LOCATIONS | HOUR | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 |
|-----------|------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
|-----------|------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|

NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE

| | | | |
|--------------|-----------------|---------------------------|--------------------|
| ARTING FOR | THROUGH | Telephone No. | Medical Record No. |
| Physician | Choudhry | Alt. Telephone | |
| rgies | | Rehabilitative Potential | |
| gnosis | NKDA | | |
| icaid Number | Medicare Number | Complete Entries Checked: | |
| By: | | | |
| IENT | Stratton | Title: | |
| | | PATIENT CODE | ROOM NO. |
| | | 77 112 411 | 2016 |
| | | BED | FACILITY CC |
| | | | 501-1 |

RECEIVED
JUL 17 2002
MEDICAL RECORDS DEPT.
SCI GRATERFORD

EDICATION ADMINISTRATION RECORD

731

| ICATIONS | HOUR | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | |
|---|----------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|--|
| Colore 1000 Tpo BID 6/30/02 | 08 20 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MOM 30 cc 1/4/02 HS PRN 6/10/02 | 20 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Mag Citrate 1 bottle 1200 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Mag Citrate 1 bottle 1/9/02 6/9/02 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Mineral oil 30cc po 08 QD 1/11/02 7/10/02 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

| ICATIONS | HOUR | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 |
|----------|------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
|----------|------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|

| | | | |
|--|--------------------|---|---------------|
| NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE | | RECEIVED | |
| ARTING FOR sician Physician rgies osis | THROUGH 6/30/02 | | |
| Telephone No. | Medical Record No. | JUL 10 2002 | |
| Alt. Telephone | | | |
| Rehabilitative Potential | | MEDICAL RECORDS DEPT. SCI/GRATERFORD | |
| | | | |
| icaid Number | Medicare Number | Complete Entries Checked: | |
| By: | Date: | Room No. | Facility Code |

MEDICATION ADMINISTRATION RECORD

DT01

| LOCATIONS | HOUR | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 |
|--|------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
| M.O.M. 30cc. PO HS PRN 1/22/02 5/8/02 20 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Dulcolax 7 Po Bid 5/16/02 X3 5/18/02 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SURFAX 7 PO BID 1/9/02 5/28/02 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

MEDICATION ADMINISTRATION RECORD

01/2002

(GRAT-192) SCI GRATERFORD CORR.

DT01

| INDICATIONS | HOUR | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 |
|---|------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
| TRONIDAZOLE (FLAGYL) 500MG TAB | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| TAKE 1 TABLET(S) BY MOUTH TWICE DAILY FOR 10 DAYS | 08 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2508414 IACCARINO, DO, ANTHONY, MD | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ART - 02/21/2002 STOP - 03/02/2002 | 20 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Colace 100mg $\dot{\bar{i}}$ po | 08 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3/5/02 3/18/02 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Colace 100mg $\dot{\bar{i}}$ po daily | 0800 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3/5/02 3/18/02 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Motrin 600mg po | 08 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3/12/02 3/22/02 | 20 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Metamucil $\dot{\bar{i}}$ pkg | 08 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3/7/02 3/22/02 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE

| | | | |
|------------|------------------------|--------------------------|--------------------|
| ARTING FOR | 03/01/2002 | THROUGH | 03/31/2002 |
| Physician | IACCARINO, DO, ANTHONY | Telephone No. | Medical Record No. |
| Physician | | Alt. Telephone | |
| argies | NO KNOWN DRUG ALLERGY | Rehabilitative Potential | |

| | | |
|--------------|-----------------|---------------------------|
| Board Number | Medicare Number | Complete Entries Checked: |
| TENT | By: | Title: |
| PATIENT CODE | ROOM NO. | DATE: |
| NP4244 | | |
| FACILITY C | | |
| GRAT- | | |

EDUCATION ADMINISTRATION RECORD

01/2002

(GRAT-192) SCI GRATERFORD CORR.

T01

| LOCATIONS | HOUR | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 |
|--|------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
| HYDROCHLORIDE (BENTYL) 2000 TAB | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4E 1 TABLET(S) BY MOUTH 3 TIMES DAILY AS | 08 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ED FOR 30 DAYS | 12 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2419101 IACCARINO, DO, ANTHONY, MD | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| RT - 01/06/2002 STOP - 02/06/2002 | 20 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| Metamucil 1 pack @ H.S. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2-3-02 2-15-02 2000 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| old set up II P.O. Bid 0800 5 days | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10-02 2-15-02 2000 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10trin 600mg 1 P.O. Bid 0800 5 days | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10-02 2-16-02 2000 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Flazyl 5mg 2h/12 3h/12 0800 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

| LOCATIONS | HOUR | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 |
|-----------|------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
|-----------|------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|

NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE

| | | | |
|----------------------------------|--------------------------|--------------------|--|
| ARTING FOR 02/01/2002 | THROUGH 02/28/2002 | | |
| Physician IACCARINO, DO, ANTHONY | Telephone No. | Medical Record No. | |
| Physician | Alt. Telephone | | |
| rgies NO KNOWN DRUG ALLERGY | Rehabilitative Potential | | |

| | | | |
|--------------|-----------------|---------------------------|------------|
| griosis | | | |
| icaid Number | Medicare Number | Complete Entries Checked: | |
| By: | Title: | PATIENT CODE | ROOM NO. |
| By: | Date: | BED | FACILITY C |
| | | GRAT- | |

3701

| INDICATIONS | HOUR | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 |
|-------------|------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
|-------------|------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|

NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE

agnosis

| | | |
|---------------|-----------------|---------------------------|
| Social Number | Medicare Number | Complete Entries Checked: |
|---------------|-----------------|---------------------------|

| | | | | | | |
|---------|---|-----|--------------|----------|-------|------------|
| | | By: | Title: | | Date: | |
| PATIENT | 2 | | PATIENT CODE | ROOM NO. | BED | FACILITY C |

EDUCATION ADMINISTRATION RECORD

T01

| CATIONS | HOUR | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 |
|---|------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
| Thiazide 20mg Q6 hr for agitation x 240 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Cdace 100mg B 68 B.D 2402 7-24-02 20 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Constant watch 1:1 suicide vest. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| suicide blanket in ger food trapped cell. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| no mattress. no pillow. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1up C psych 6-25-02 | AM | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

| ICATIONS | HOUR | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 |
|--|------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
| ADM 6/24/02 ARTING FOR 6/02 sician SMITH Physician rgies NKDA osis R/O S.I aid Number Medicare Number Complete Entries Checked: By: Title: PATIENT CODE ROOM NO. BED FACILITY C | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE | | Dob 11-4-76 HX: GSW Abol + LT leg. Chronic Constipation Chronic Abol pain Telephone No. Alt. Telephone Rehabilitative Potential | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Date: | | 6-25-02 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

(GRAT-192 3C1 GRATERFORD CORR.

[illegible]

| INDICATIONS | DATE | HOUR | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 |
|-------------|------|------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
|-------------|------|------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|

| | | | | |
|--------------|--|------------|------------------------|--------------------------|
| STARTING FOR | | 01/01/2002 | THROUGH | 01/31/2002 |
| Physician | | | IACCARINO, DO, ANTHONY | Telephone No. |
| Physician | | | | Alt. Telephone |
| Allergies | | | NO KNOWN DRUG ALLERGY | Rehabilitative Potential |

| | | |
|-------------|-----------------|------------------------------------|
| Card Number | Medicare Number | Complete Entries Checked: |
| | | By: _____ Title: _____ Date: _____ |

| | | | | |
|-----|--------------|----------|-----|------------|
| ENT | PATIENT CODE | ROOM NO. | BED | FACILITY C |
| ENT | ENT-1 | 1 | | ENT-1 |

3T01

| INDICATIONS | | HOUR | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | |
|-------------|----------|----------|----|---|---|---|---|---|----|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|--|
| tylenol | 11/11/01 | 11/11/02 | 08 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| zantac | 11/11/01 | 11/11/02 | 08 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| zantac 150 | 11/11/01 | 11/11/02 | 08 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| colace 100 | 11/11/01 | 11/11/02 | 08 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | </ | | | | | | | | | | | | | | | | | | | | | | | | |

| EDICATIONS | | HOUR | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 |
|--|--|--------------------------|--|---------------------------|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
| NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ARTING FOR | | THROUGH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Physician | | Telephone No. | | Medical Record No. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Physician | | Alt. Telephone | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ergies | | Rehabilitative Potential | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| gnosis | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| icaid Number | | Medicare Number | | Complete Entries Checked: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IENT | | By: | | Title: Date: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PATIENT CODE | | ROOM NO. | | BED FACILITY C | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

MEDICATION ADMINISTRATION RECORD

10/02/2001

(GRAT-192) SCI GRATERFORD CORR.

DT01

| EDICATIONS | HOUR | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 |
|------------|------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
|------------|------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|

CUSATE SOD (COLACE) (CAROS) 100MG CAP

KE 1 CAPSULE(S) BY MOUTH DAILY FOR 30

YS

: 2234378 KOTCH, MD, SAMUEL, MD

ART - 10/16/2001 STOP - 11/14/2001

YLLIUM INST (HYDROCI-METAMU) 5.85GM PKT

SSOLVE 2 PACKET(S) IN LIQUID & DRINK AT

D TIME FOR 30 DAYS

: 2243689 HOVICK, MD, , MD

ART - 10/18/2001 STOP - 11/16/2001

Pento Bismol 200u

PO BID PRN

1/23/01

12/1/01

| EDICATIONS | HOUR | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 |
|------------|------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
|------------|------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|

NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE

| | | | |
|--------------|-----------------------|----------------|--------------------------|
| STARTING FOR | 11/01/2001 | THROUGH | 11/30/2001 |
| Physician | HOVICK, MD, | Telephone No. | Medical Record No. |
| Physician | | Alt. Telephone | |
| ergies | NO KNOWN DRUG ALLERGY | | Rehabilitative Potential |

agnosis

| | | | | | | |
|-----------------|-----------------|---------------------------|--------------|----------|-------|----------|
| Medicaid Number | Medicare Number | Complete Entries Checked: | Title: | | Date: | |
| | | By: | PATIENT CODE | ROOM NO. | BED | FACILITY |
| | | | 004244 | F | | GRAT |

2T01

| LOCATIONS | HOUR | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 |
|-----------|------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
|-----------|------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|

NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE

| | | | | |
|---------------------|--------------|----------|-----|---------------|
| NT | PATIENT CODE | ROOM NO. | BED | FACILITY CODE |
| 2.10.11 08:12 AM 44 | 284211 | 2:15 | | |

8/01

| EDICATIONS | HOUR | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 |
|------------|------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
|------------|------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|

29 Apr

28th

28101

84 lab

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| | | | | |

| | | | | |
|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 |
| | | | | |

[illegible]

| | | | | |
|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|

3, MEDICATION NOT

| | | | |
|--------------|--------------------------|--------------------|--|
| STARTING FOR | | THROUGH | |
| Physician | Telephone No. | Medical Record No. | |
| Physician | Alt. Telephone | | |
| Notes | Rehabilitative Potential | | |

| | | | | | | | |
|-------------------------------|--|----------------------------------|--|--------------------------|--|----------------|--|
| ICD Number Medicare Number | | Complete Entries Checked: By: | | Title: | | Date: | |
| ENT <i>Pearl</i> | | <i>DP 4341</i> | | PATIENT CODE <i>5</i> | | ROOM NO. | |
| | | | | | | BED FACILITY C | |

MEDICATION ADMINISTRATION RECORD

DT01

| MEDICATIONS | | HOUR | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | |
|-------------------------|------------|------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|--|
| Bentyl 10mg cap of | 7/17/01 20 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| T cap PO BID | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Ampicillin 500mg of | 7/17/01 20 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PO BID | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Given on St. K. (a. 11) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE

| | | | |
|-----------|---------|--------------------------|--------------------|
| RTING FOR | THROUGH | Telephone No. | Medical Record No. |
| cian | | Alt. Telephone | |
| hysician | | Rehabilitative Potential | |

osis

| | | |
|-----------|-----------------|---------------------------|
| id Number | Medicare Number | Complete Entries Checked: |
| | | By: |

| | | | | |
|------|--------------|----------|-----|---------------|
| NT | Title: | Room No. | Bed | Facility Code |
| P... | PATIENT CODE | 15 | | |

| EDICATIONS | HOUR | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 |
|------------|------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
|------------|------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|

| EDICATIONS | HOUR | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 |
|------------|------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
|------------|------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|

gnosis

| | | |
|--------------|-----------------|---------------------------|
| icaid Number | Medicare Number | Complete Entries Checked: |
|--------------|-----------------|---------------------------|

By: _____ Title: _____ Date: _____

| | | | | |
|---------|--------------|----------|-----|----------|
| PATIENT | PATIENT CODE | ROOM NO. | BED | FACILITY |
|---------|--------------|----------|-----|----------|

| | | | |
|-------|---------|----|------|
| Don't | ND/1246 | 1) | Scit |
|-------|---------|----|------|

5/1

2T01

| EDICATIONS | | HOUR | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 |
|---------------------------------|--|------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
| Tis Detayn + prob OB 5/31 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE

| | | | |
|-------------|----------------|--------------------------|--------------------|
| ARTING FOR | | THROUGH | |
| ysician | Telephone No. | | Medical Record No. |
| . Physician | Alt. Telephone | | |
| ergies | | Rehabilitative Potential | |

agnosis

| | | | | | | | | | |
|--------------|--|-----------------|--|---------------------------|--|--------------|----------|-----|---------------|
| icaid Number | | Medicare Number | | Complete Entries Checked: | | | | | |
| | | | | By: | | Date: | | | |
| PATIENT | | PEARSON | | DP 424G | | PATIENT CODE | ROOM NO. | BED | FACILITY CODE |
| | | | | | | 5 | | | |

3T01

| EDICATIONS | HOUR | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 |
|------------|------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
|------------|------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|

NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE

gnosis

| | | | | | | |
|-------|------|--------------|---------|----------|-----|---------------|
| IDENT | PEAR | PATIENT CODE | DP 4246 | ROOM NO. | BED | FACILITY CODE |
|-------|------|--------------|---------|----------|-----|---------------|

[illegible]

| EDICATIONS | HOUR | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 |
|------------|------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
|------------|------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|

| | | | |
|---------------------------------|--|--------------------------|--------------------|
| STARTING FOR <u>2/1/01</u> | | THROUGH <u>2/28/01</u> | |
| Physician | | Telephone No. | Medical Record No. |
| Physician | | Alt. Telephone | |
| Ergies <u>NUT, NUT PRODUCTS</u> | | Rehabilitative Potential | |

agnosis .

| | | | | |
|----------------|-----------------|---------------------------|--------|-------|
| Medical Number | Medicare Number | Complete Entries Checked: | | |
| | | By: | Title: | Date: |

| | | | | |
|----------------|--------------|----------|-----|---------------|
| PATIENT | PATIENT CODE | ROOM NO. | BED | FACILITY CODE |
| PEAY, SIMOTHAN | DP4246 | D | | |

DT01

[illegible]

NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE

| | | | | | |
|---------------|--|--------------------------|--|---------------------------|-----------------|
| ARTING FOR | | THROUGH | | 01 OCT 2000 | |
| Physician | | Telephone No. | | Medical Record No. | |
| Physician | | Alt. Telephone | | | |
| Surgery | | Rehabilitative Potential | | | |
| Diagnosis | | | | | |
| Social Number | | Medicare Number | | Complete Entries Checked: | |
| | | By: | | Date: | |
| PATIENT | | PATIENT CODE | | ROOM NO. | BED FACILITY CC |
| P. 1000 | | 084246 | | 0 | 260 |

[illegible]

| EDICATIONS | | | HOUR | | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 |
|--|--|--|--------|--|--|-----------------|---|---|---------|---|---|---------------------------|---|---|----|----|----|--------------------------|----|----|----|----|----|-----|----|----|----|----|----|--------------------|----|----|----|----|----|
| NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ARTING FOR | | | 7-1-00 | | | THROUGH | | | 7-31-00 | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Physician | | | | | | | | | | | | | | | | | | Telephone No. | | | | | | | | | | | | Medical Record No. | | | | | |
| Physician | | | | | | | | | | | | | | | | | | Alt. Telephone | | | | | | | | | | | | | | | | | |
| Surgeries | | | | | | | | | | | | | | | | | | Rehabilitative Potential | | | | | | | | | | | | | | | | | |
| Diagnosis | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Insurance Number | | | | | | Medicare Number | | | | | | Complete Entries Checked: | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | By: | | | | | | | | | | | | | | | | | | | | | | | |
| PATIENT CODE | | | | | | | | | | | | | | | | | | ROOM NO. | | | | | | BED | | | | | | FACILITY CODE | | | | | |
| 004246 | | | | | | | | | | | | | | | | | | D | | | | | | | | | | | | 5116 | | | | | |

PRINTED

FACILITY

SCIG

BLOCK

E

MO

4

YR

00

PAGE

Letrimen Cream

BID

Kap

4-27

Dec 4 7:41 00

off

DIAGNOSIS:

ALLERGIES:

PHYSICIAN:

PATIENT

DIET:

PATIENT NO.

DP 4.246

- A. PUT INITIAL IN APPROPRIATE BOX WHEN MEDICATION GIVEN.
B. CIRCLE INITIALS WHEN MEDICATION REFUSED.
C. STATE REASON FOR REFUSAL ON NURSE'S NOTES
D. PRN MEDICATIONS: REASON GIVEN AND RESULTS SHOULD BE NOTED ON NURSE'S PRN NOTES.
E. INDICATE SITE OF INJECTION WITH APPROPRIATE NUMBER (SEE BELOW):

- INJECTION SITE NUMBERS
1. BUTTOCKS (GLUTEUS) LEFT
2. BUTTOCKS (GLUTEUS) RIGHT
3. ARM (DELTOID) LEFT

4. ARM (DELTOID) RIGHT
5. THIGH (QUADRICEPS) LEFT
6. THIGH (QUADRICEPS) RIGHT

PRINTED

FACILITY

BLOCK

YR

MO

PAGE

SC16

E

1 00

1

D/C
DATE

HOUR

Neosporin oint

FLD

1-15

kep

1-16

mot-in 800mg

+10

1-29

kep

1-24

gum
EAM/1-26-03

DIAGNOSIS:

ALLERGIES:

PHYSICIAN:

PATIENT

DIET:

PATIENT NO.

Penis

NO. 246

A. PUT INITIAL IN APPROPRIATE BOX WHEN MEDICATION GIVEN.
B. CIRCLE INITIALS WHEN MEDICATION REFUSED.
C. STATE REASON FOR REFUSAL ON NURSE'S NOTES
D. PRN MEDICATIONS: REASON GIVEN AND RESULTS SHOULD BE NOTED ON NURSE'S PRN NOTES.
E. INDICATE SITE OF INJECTION WITH APPROPRIATE NUMBER (SEE BELOW):

INJECTION SITE NUMBERS

- 1. BUTTOCKS (GLUTEUS) LEFT
- 2. BUTTOCKS (GLUTEUS) RIGHT
- 3. ARM (DELTOID) LEFT
- 4. ARM (DELTOID) RIGHT
- 5. THIGH (QUADRICEPS) LEFT
- 6. THIGH (QUADRICEPS) RIGHT

PRINTED

FACILITY

SC16

BLOCK

YR

MO

PAGE

10 99

Case 2:02-cv-02688-SD Document 45-6 Filed 08/15/2003 Page 8 of 153

D/C
DATE

HOUR

10-29

Kelex 500 mg

T-10

11-7

Pop

~~SC16~~

DIAGNOSIS:

ALLERGIES:

PHYSICIAN:

PATIENT

DIET:

PATIENT NO.

08 4246

A. PUT INITIAL IN APPROPRIATE BOX WHEN MEDICATION GIVEN.
B. CIRCLE INITIALS WHEN MEDICATION REFUSED.
C. STATE REASON FOR REFUSAL ON NURSE'S NOTES
D. PRN MEDICATIONS: REASON GIVEN AND RESULTS SHOULD BE NOTED ON NURSE'S PRN NOTES.
E. INDICATE SITE OF INJECTION WITH APPROPRIATE NUMBER (SEE BELOW):

INJECTION SITE NUMBERS
1. BUTTOCKS (GLUTEUS) LEFT
2. BUTTOCKS (GLUTEUS) RIGHT
3. ARM (DELTOID) LEFT
4. ARM (DELTOID) RIGHT
5. THIGH (QUADRICEPS) LEFT
6. THIGH (QUADRICEPS) RIGHT

PRINTED
9/16/99

FACILITY
SCICG

BLOCK
L

MO
9

YR
99

PAGE

| D/C DATE | | HOUR | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | |
|---------------------------------------|--|------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|--|
| 9/3/99 | | 08 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Bactrim DS T PO BID x 7 days | | 20 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Motrin 600mg T tab PO TID | | 08 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 9/16/99 | | 12 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Amoxicillin 500mg cap T cap PO TID | | 20 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 9/16/99 | | 08 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | 12 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | 20 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Bactrim DS T

PO BID

X 7 days

Motrin 600mg TID

PO TID

Amoxicillin 500mg cap

T cap PO TID

DIAGNOSIS:

ALLERGIES:

PHYSICIAN:

Kalayut

PATIENT

Pen. S

PATIENT NO.

DP 4711

DIET:

A. PUT INITIAL IN APPROPRIATE BOX WHEN MEDICATION GIVEN.
B. CIRCLE INITIALS WHEN MEDICATION REFUSED.
C. STATE REASON FOR REFUSAL ON NURSE'S NOTES
D. PRN MEDICATIONS: REASON GIVEN AND RESULTS SHOULD BE NOTED ON NURSE'S PRN NOTES.
E. INDICATE SITE OF INJECTION WITH APPROPRIATE NUMBER (SEE BELOW)

INJECTION SITE NUMBERS
1. BUTTOCKS (GLUTEUS) LEFT
2. BUTTOCKS (GLUTEUS) RIGHT
3. ARM (DELTOID) LEFT
4. ARM (DELTOID) RIGHT
5. THIGH (QUADRICEPS) LE
6. THIGH (QUADRICEPS) RI

PRINTED

FACILITY

Mra

BLANK

MO 5 YR 99

PAGE

Case 2:02-cv-02688-SD Document 45-6 Filed 08/15/2003 Page 8 of 153

D/C
DATE

HOUR

Tegamet
800mg
b.i.d.

5-13
44p

5/13/99 Q. Feay

DIAGNOSIS:

ALLERGIES:

PHYSICIAN:

DIET:

PATIENT

PATIENT NO.

DP4241

Feay

A. PUT INITIAL IN APPROPRIATE BOX WHEN MEDICATION GIVEN.
B. CIRCLE INITIALS WHEN MEDICATION REFUSED.
C. STATE REASON FOR REFUSAL ON NURSE'S NOTES
D. PRN MEDICATIONS: REASON GIVEN AND RESULTS SHOULD BE NOTED ON NURSE'S PRN NOTES.
E. INDICATE SITE OF INJECTION WITH APPROPRIATE NUMBER (SEE BELOW):

INJECTION SITE NUMBERS
1. BUTTOCKS (GLUTEUS) LEFT
2. BUTTOCKS (GLUTEUS) RIGHT
3. ARM (DELTOID) LEFT
4. ARM (DELTOID) RIGHT
5. THIGH (QUADRICEPS) LEFT
6. THIGH (QUADRICEPS) RIGHT

DIAGNOSIS:

ALLERGIES:

PHYSICIAN:

PATIENT

- A. PUT INITIAL IN APPROPRIATE BOX WHEN MEDICATION GIVEN.
- B. CIRCLE INITIALS WHEN MEDICATION REFUSED.
- C. STATE REASON FOR REFUSAL ON NURSE'S NOTES
- D. PRN MEDICATIONS: REASON GIVEN AND RESULTS SHOULD BE ON NURSE'S PRN NOTES.
- E. INDICATE SITE OF INJECTION WITH APPROPRIATE NUMBER (S)

INJECTION SITE NUMBERS

INJECTION SITE NUMBERS

1. BUTTOCKS (GLUTEUS) LEFT

2. BUTTOCKS (GLUTEUS) RIGHT

4. ARM (DELTOID) RIGHT

5. THIGH (QUADRICEPS) LEFT

6. THIGH (QUADRICEPS) RIG

| |
|-------------|
| PATIENT NO. |
|-------------|

Peew

DP 4246

PRINTED

FACILITY

SC16

BLOCK

F

PAGE

MO

YR

12/24

TAGAMET 300mg

12/24 TID BID

WALLOX

12/24 300c & TID

D/C DATE

1/1

HOUR

08

20

08

12

20

given 12-24-SS

KOP

KOP

DIAGNOSIS:

ALLERGIES:

PHYSICIAN:

PATIENT

DEAY

PATIENT NO.

704746

DIET:

- A. PUT INITIAL IN APPROPRIATE BOX WHEN MEDICATION GIVEN.
- B. CIRCLE INITIALS WHEN MEDICATION REFUSED.
- C. STATE REASON FOR REFUSAL ON NURSE'S NOTES
- D. PRN MEDICATIONS: REASON GIVEN AND RESULTS SHOULD BE NOTED ON NURSE'S PRN NOTES.
- E. INDICATE SITE OF INJECTION WITH APPROPRIATE NUMBER (SEE BELOW):

INJECTION SITE NUMBERS
1. BUTTOCKS (GLUTEUS) LEFT
2. BUTTOCKS (GLUTEUS) RIGHT
3. ARM (DELTOID) LEFT

4. ARM (DELTOID) RIGHT
5. THIGH (QUADRICEPS) LEFT
6. THIGH (QUADRICEPS) RIGHT

[illegible]

May 98

| STOP DATE | HOUR | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 |
|-----------|------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
| 5/22/98 | 5 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5/22/98 | 1 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5/22/98 | 2 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5/22/98 | 3 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5/22/98 | 4 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5/22/98 | 5 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5/22/98 | 6 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5/22/98 | 7 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5/22/98 | 8 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5/22/98 | 9 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5/22/98 | 10 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5/22/98 | 11 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5/22/98 | 12 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5/22/98 | 13 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5/22/98 | 14 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5/22/98 | 15 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5/22/98 | 16 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5/22/98 | 17 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5/22/98 | 18 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5/22/98 | 19 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5/22/98 | 20 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5/22/98 | 21 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5/22/98 | 22 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5/22/98 | 23 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5/22/98 | 24 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5/22/98 | 25 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5/22/98 | 26 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5/22/98 | 27 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5/22/98 | 28 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5/22/98 | 29 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5/22/98 | 30 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

| | | |
|----------------|---------|----------|
| ALLERGY | NKA | |
| DIAGNOSIS | | |
| PHYSICIAN NAME | Jusky | |
| FACILITY NAME | SECTION | ROOM NO. |
| PATIENT NAME | PEAY | DP 4246 |

INTER-INSTITUTIONAL MEDICAL RECORD TRANSFER CHECKLIST

 From SCI: Camp Hill to SCI: Graterford

 Date of Transfer: 8/21/98

| Required Contents | Sending Facility | Receiving Facility |
|---|------------------|--------------------|
| 1. Intake Screening Form or Reception Summary | ✓ | ✓ |
| 2A. Current PPD and TB Summary Sheet | ✓ | ✓ |
| 2B. Computer Data Entry Complete | ✓ | ✓ B3 |
| 3. Dental Record | ✓ | ✓ |
| 4. History and Physical Exam | ✓ | ✓ |
| 5. Integrated Psych Records/SNU Records | ✓ | ✓ |
| 6. Laboratory Exams: CBC, Diff, STS, U/A, Sickie Cell, HIV, Culture Reports | ✓ | ✓ |
| 7. Diagnostic Reports: audio/visual, MRI, ultrasound, bone scan, etc. | ✓ | ✓ |
| 8. Consultation Reports on-site and off-site | No | NA |
| 9. All Xrays: Reports and films | ✓ | ✓ |
| 10. EKG Baseline: If older than 40 or history of heart problems | No | NA |
| 11. All Progress Notes/Physician Orders | ✓ | ✓ |
| 12. Inpatient Unit Records/Special Unit Records | No | NA |
| 13. Community Hospitalization/Emergency Room Records | No | NA |
| 14. MARS (old) | ✓ | ✓ |
| 15. I.D. Card | No | NA |
| 16. Medications | No | NA |

Make sure loose filing is retrieved from all appropriate locations. (i.e. infirmary, repository, mail, etc...)

Comments:

A.R.T. or Designee Sending Facility: Shawn Madden Date: 8/19/98
 A.R.T. or Designee Receiving Facility: Pauline Zamoski Date: 8-24-98
 WHITE - Receiving institution under miscellaneous CANARY - Sending institution file copy

Inter-institutional Medical Record
 Transfer Checklist
 Commonwealth of Pennsylvania
 Department of Corrections
 DC-485

Inmate Name: Peay Stratton
 Inmate Number: DP 4246
 DOB: 11-4-76
 Institution: CH

| NURSING TRANSFER CHECKLIST | | YES | NO |
|--|--|-----|-------------------------------------|
| 1. Does the inmate have active TB disease? | | | <input checked="" type="checkbox"/> |
| 2. Does the TB Summary need to be completed? (If yes, complete 2a - 2d) | | | <input checked="" type="checkbox"/> |
| a. Is the inmate a past positive? (circle one) Yes <input checked="" type="checkbox"/> No | b. If yes, was INH therapy started? Yes No | | |
| c. Date of last chest x-ray? 4-27-98 | d. Result? Positive <input checked="" type="checkbox"/> Negative | | |
| 2. Is the inmate in medical isolation? | | | <input checked="" type="checkbox"/> |
| 3. RPR? Positive <input checked="" type="checkbox"/> Negative If positive, does the inmate need to be cleared through the ICN? | | | <input checked="" type="checkbox"/> |
| 4. Does the record indicate an unstable, uncontrolled or acute condition which needs to be resolved or identified? | | | |
| 5. Does the inmate have an acute or unresolved infection? | | | |
| 6. Does the inmate have a pending consultation? (Look for both the Consultation Record Form and a note in progress notes) | | | <input checked="" type="checkbox"/> |
| 7. Is the inmate in the process of receiving dental surgical procedures or dentures? | | | <input checked="" type="checkbox"/> |
| 8. Is there any indication that the inmate is in need of immediate surgery or is the inmate undergoing post- surgical care? | | | <input checked="" type="checkbox"/> |
| 9. Has the physician or PA determined that the inmate is not physically able to travel? | | | <input checked="" type="checkbox"/> |
| 10. Has the inmate had a serious accident or overdose in the last 24 hours? | | | <input checked="" type="checkbox"/> |
| 11. Has the inmate been housed in the Infirmary, Psychiatric Observation Cell or Mental Health Unit within the past 7 days? | | | <input checked="" type="checkbox"/> |
| 12. Does the record indicate evidence of clinical signs/symptoms of serious mental illness? | | | <input checked="" type="checkbox"/> |
| 13. Are there any missing consults, lab work or x-rays? (ordered but not on chart) | | | <input checked="" type="checkbox"/> |
| 14. Is there any lab work, x-rays, consultation report, test results without a physician's signature/initials? | | | <input checked="" type="checkbox"/> |

Circle current chronic medical problems: Seizure Asthma Diabetes HTN HIV TB prophylaxis Neuroleptics

**If there are any checkmarks in the YES column,
the chart MUST be reviewed with the physician for determination of hold status.**

Comments: _____

Reviewed with the physician?

Yes

☒ No

R. Lindsay RN
Sending Facility Nurse Signature

8-18-98
Date/Time 1325

Receiving Facility Nurse Signature

Date/Time

Nursing Transfer Checklist
Commonwealth of Pennsylvania
Department of Corrections
DC-491

Inmate Name: Reay, STRATTON

Inmate Number: DP-4246

DOB: 11-04-1976

Institution: SCI-Camp Hill

| NURSING TRANSFER CHECKLIST | | YES | NO |
|---|--|----------|----------|
| 1. Does the inmate have active TB disease? | | | / |
| 2. Does the TB Summary need to be completed? (If yes, complete 2a - 2d) | | | / |
| a. Is the inmate a past positive? (circle one) Yes No | b. If yes, was INH therapy started? Yes No | //////// | //////// |
| c. Date of last chest x-ray? <u>4/27/98</u> | d. Result? Positive <u>Negative</u> | //////// | //////// |
| 3. Is the inmate in medical isolation? | | | / |
| 4. RPR? Positive Negative If positive, does the inmate need to be cleared through the ICN? | | | N/A |
| 5. Does the record indicate an unstable, uncontrolled or acute condition which needs to be resolved or identified? | | | / |
| 6. Does the inmate have an acute or unresolved infection? | | | / |
| 7. Does the inmate have a pending consultation? (Look for both the Consultation Record Form and a note in progress notes) | | | / |
| 8. Is the inmate in the process of receiving dental surgical procedures or dentures? | | | / |
| 9. Is there any indication that the inmate is in need of immediate surgery or is the inmate undergoing post-surgical care? | | | / |
| 10. Has the physician or PA determined that the inmate is not physically able to travel? | | | / |
| 11. Has the inmate had a serious accident or overdose in the last 24 hours? | | | / |
| 12. Has the inmate been housed in the Infirmary, Psychiatric Observation Cell or Mental Health Unit within the past 7 days? | | | / |
| 13. Does the record indicate evidence of clinical signs/symptoms of serious mental illness? | | | / |
| 14. Are there any missing consults, lab work or x-rays? (ordered but not on chart) | | | / |
| 15. Is there any lab work, x-rays, consultation report, test results without a physician's signature initials? | | | / |
| 16. Is there any labwork, x-rays, consultation report, test results which require follow-up? | | | / |
| 17. Is inmate a dialysis patient? | | | / |
| 18. Have dialysis arrangements been made at receiving institution? | | | / |
| 19. Date of Last Dialysis Treatment: | | //////// | //////// |

Circle current chronic medical problems: Seizure Asthma Diabetes HTN HIV TB prophylaxis Neuroleptics

If there are any checkmarks in the YES column,
the chart MUST be reviewed with the physician for determination of hold status.

Comments:

Cleared for Transfer

Reviewed with the physician?

Yes

No

Nurse Signature

Date

Time

Physician/PA Name:

| | |
|--|------------------------------------|
| Nursing Transfer Checklist Commonwealth of Pennsylvania Department of Corrections DC- | Inmate Name: <u>Peay, Stratton</u> |
| | Inmate Number: <u>DP 4246</u> |
| | DOB: |
| | Institution: |

INTER-INSTITUTIONAL MEDICAL RECORD TRANSFER CHECKLIST

From SCI: GRATERFORDto SCI: CDCC/CAMP HILLDate of Transfer: 5-6-98

| Required Contents | Sending Facility | Receiving Facility |
|---|------------------|--------------------|
| 1. Intake Screening Form or Reception Summary | ✓ | ✓ |
| 2. History and Physical Exam | NA | na |
| 3. Laboratory Exams: CBC, Diff, STS, U/A, Sickie Cell, HIV, Culture Reports | NA | na |
| 4. EKG Baseline: If older than 40 or history of heart problems | NA | na |
| 5A. Current PPD and TB Summary Sheet | ✓ | ✓ |
| 5B. Computer Data Entry Complete | ✓ | ✓ |
| 6. Dental Record | NA | na |
| 7. All Xrays: Reports and films | ✓ | ✓ |
| 8. Inpatient Unit Records/Special Unit Records | NA | na |
| 9. Community Hospitalization/Emergency Room Records | NA | na |
| 10. Diagnostic Reports: audio/visual, MRI, ultrasound, bone scan, etc. | NA | na |
| 11. Consultation Reports: on-site and off-site | NA | na |
| 12. All Progress Notes/Physician Orders | ✓ | ✓ |
| 13. Integrated Psych Records/SNU Records | NA | na |
| 14. MARS (old) | NA | na |
| 15. I.D. Card | NA | na |
| 16. Medications | NA | na |

Make sure loose filing is retrieved from all appropriate locations. (i.e. infirmary, repository, mail, etc...)

Comments:

Audrey Zamorski ALT 5-4-98

R.T. or Designee Sending Facility

Date

B Kent MAA

A.R.T. or Designee Receiving Facility

Date

5/6/98

Original - receiving institution under miscellaneous

Copy - Sending institution file copy

Inter-institutional Medical Record
Transfer Checklist
Commonwealth of Pennsylvania
Department of Corrections
C-485

Inmate Name:

Pray, Stratton

Inmate Number:

DP 4246

DOB:

Institution:

SCI-Graterford

TRANSFER HEALTH INFORMATION

Sending Facility: RICC Date: 4-24-98 Time: 6³⁰ AM
 Receiving Facility: SCIG Date of Transfer: 4-24-98
 Allergies/Drug Sensitivities: NKDA
 Current Acute Health Problems: None

Chronic Health Problems: None

Current Medications (Name, Dosage, Frequency, Duration, Route): None

Other Treatment: N/A

Follow-up Care Needed: None

Other Significant Medical History: None

Restrictions (Dietary, Housing, Employment): None

Pending Specialty Referrals (Appointment date if available): None

Physical Disabilities / Limitations: No

Assistive Devices / Prosthetics: None Eyeglasses: ☐ Yes ☐ No

MENTAL HEALTH HISTORY:

Substance Abuse: ☐ Yes ☒ No Specify: _____

☐ History of Suicide Attempt: Date of last attempt: _____

☐ History of Psychotropic Medication Specify: _____

TB INFORMATION

Date of last PPD 12-3-97 Result: ☒ Negative ☐ Positive mm: _____

Date of last chest x-ray _____ Result: _____

☐ History of TB prophylaxis: Medication _____ Start Date _____ Stop Date _____

☐ History of treatment for TB disease: Medication _____

Start Date _____ Stop Date _____

RPR 12-3-97 Non-Reactive

Transfer Health Information

Kathryn Weber 4-24-98
 Nurse Signature, Title Date

Inmate Name: Peay, Stratton

Inmate Number: 9621466/760822

DOB: 11-4-76

Institution: RICC

Sinus rhythm
*** report made without knowing patient's sex or age ***

09/09/01 10:37:57

ID: #STAT#010909103757

| | |
|----------------|--------------|
| Vent. Rate: | 63 bpm |
| P Duration: | 74 ms |
| QRS Duration: | 80 ms |
| PR Interval: | 110 ms |
| QT Interval: | 386 ms |
| QTc Interval: | 389 ms |
| QT Dispersion: | 24 ms |
| P-R-T AXIS: | -16° 76° 17° |

D.O.B.: 11-4-76

Loc: 1

DP4246

Peay, Stratten

Normal ECG

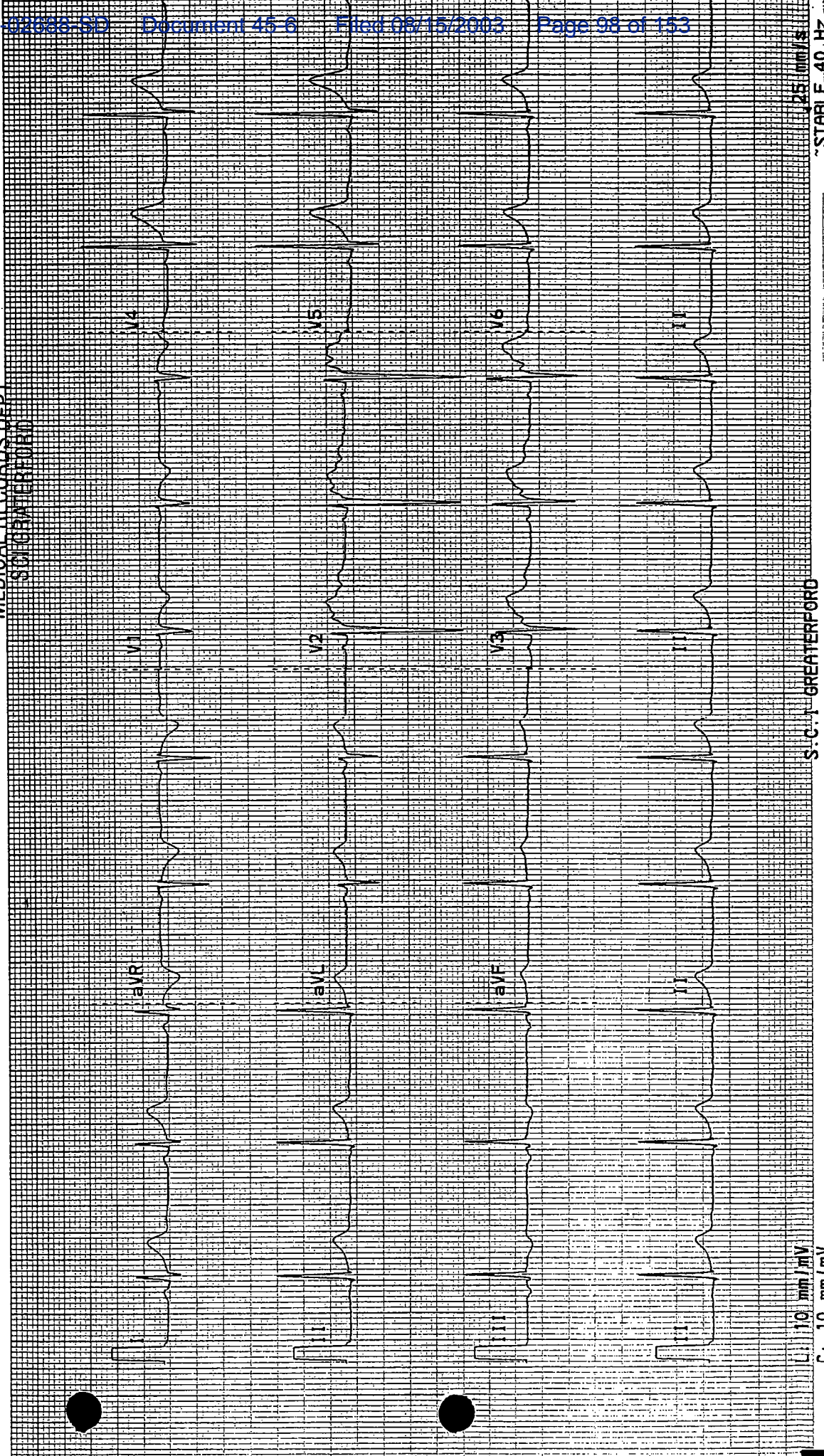
RECEIVED

SEP 10 2001

* Unconfirmed Analysis *

[Signature]
DENNIS IACCARINO D.O.
PHS PHYSICIAN

MEDICAL RECORDS DEPT
S.C. GREATERFORD



10 mm/mV
10 mm/mV

S.C. GREATERFORD

25 mm/s
~STARLF 40 Hz

ID: #STAT#010824154114

D.O.B.:
Loc: 1

leary stott
OP 42X6

Vent. Rate: 69 bpm
P Duration: 100 ms
QRS Duration: 74 ms
PR Interval: 132 ms
QT Interval: 398 ms
QTc Interval: 412 ms
QT Dispersion: 38 ms
P-R-T AXIS: 10° 85° 23°

Normal ECG * Unconfirmed Analysis *

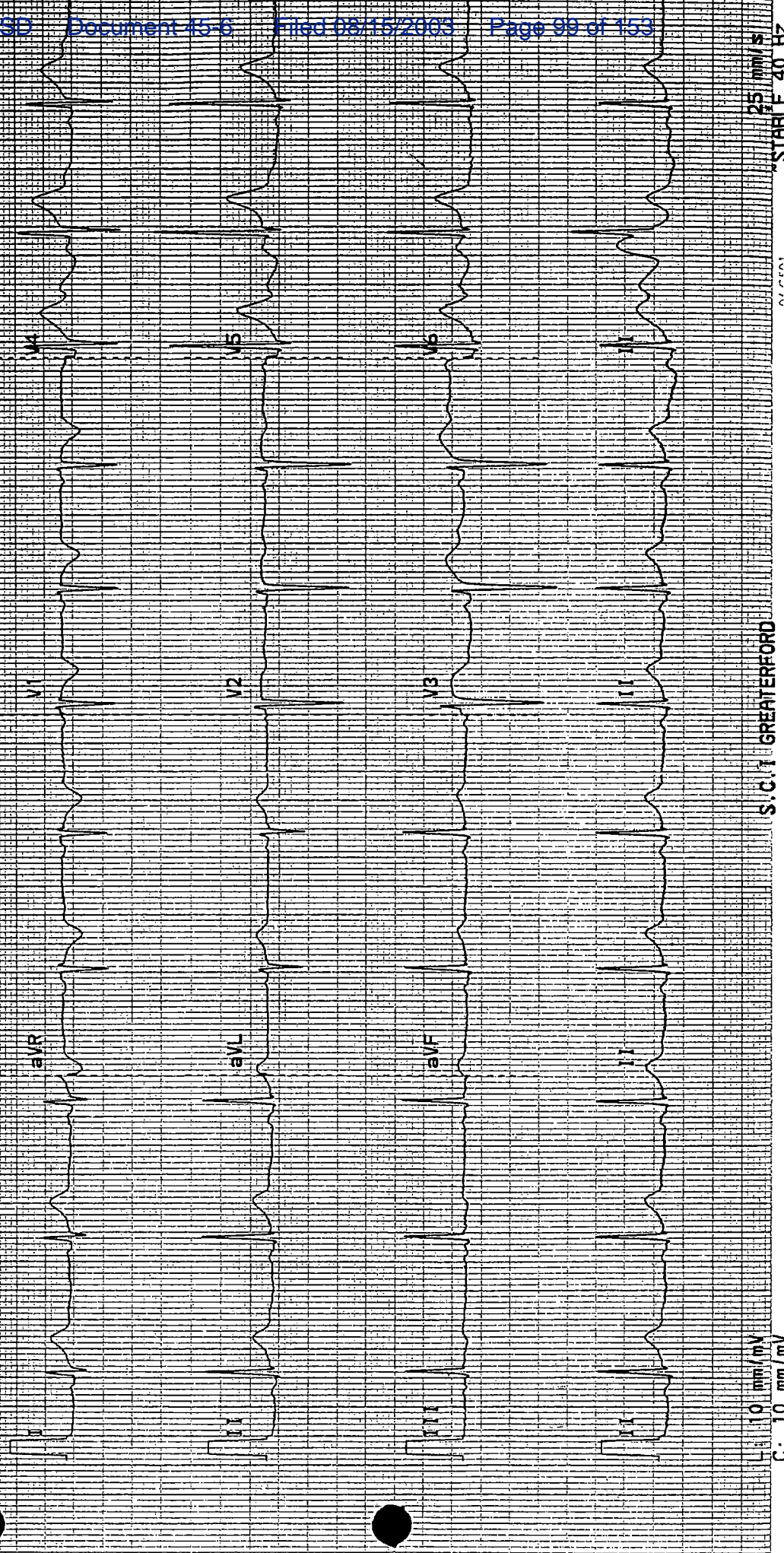
Name: John 1240 Physician
Date / Time: 1240

A NCS
Reed

RECEIVED

AUG 27 2001

MEDICAL RECORDS DEPT
SIOUX FALLS



L: 10 mm/mV
C: 10 mm/mV

S.I.C.1 GREATERFORD

25 mm/s
STABLE 40 Hz

MEDICAL CLEARANCE FORM**TYPE**

- ☒ Initial Classification ☐ Annual Physical ☐ Revision due to change in Health Status
☐ Parole Violator, CCC returns, ☐ Biennial Physical ☐ Boot Camp Clearance
returned escapees, ATA, HVA,
with more than six months absence

FOOD SERVICE

- ☒ Is approved for food service. ☐ Is not approved for food service.

MEDICAL CLEARANCE (Please Check as appropriate:)

Is medically cleared without limitations for: ☒ Regular Housing ☒ Employment ☒ Activities

Is medically cleared with the following limitations:

Housing: _____

Employment: _____

Activities: _____

Other: _____

Is not medically cleared for: ☐ Regular Housing ☐ Employment ☐ Activities

PHIL RICHARDSON, PA-C
PHYSICIAN ASSISTANT - WHS

Signature

12 MAY 1998

Date/Time

Original - Medical Records

Copy - Inmate Employment Office

Copy - Activities Copy - Other

Medical Clearance Form
Commonwealth of Pennsylvania
Department of Corrections
DC - 480

Inmate Name:

Peay, Stratton

Inmate Number:

DP4246

DOB:

11/4/76

Institution:

Sci Camp Hill

| | | | |
|--|---------------|--|--------------------------------|
| (1) Name S. Peay | | (2) DC# DP-4246 | (3) Assigned PSA B. Lachure |
| (4) ICD Code 301.9 | (5) GAF 65 | (6) Assigned Psychiatrist Dr. Henniphan | |
| (7) Date of Last Treatment Plan Review | | | |

Review/Updates

RECEIVED

AUG 21 2002

MEDICAL RECORDS DEPT.

- Inmate said suicidal so no
(17) Client Signature/Date Jan 19/20

(19) Counselor Signature _____ Date _____

Robert L. Loran 8/21/02
(18) Psychology Staff/Date (2)
Signature

(20) Psychiatrist Signature/Date (21)
Violet P. Kenigsmayr
08/21/00

(21) Unit Manager Signature/Date

Date 7-15-02

Inmate Name PEAT

DC# DP 4A4

0600 - 1400

1400 - 2200

2200 - 0600

| | | |
|-------|-------|-------|
| 6:00 | 2:00 | 10:00 |
| 6:15 | 2:15 | 10:15 |
| 6:30 | 2:30 | 10:30 |
| 6:45 | 2:45 | 10:45 |
| 7:00 | 3:00 | 11:00 |
| 7:15 | 3:15 | 11:15 |
| 7:30 | 3:30 | 11:30 |
| 7:45 | 3:45 | 11:45 |
| 8:00 | 4:00 | 12:00 |
| 8:15 | 4:15 | 12:15 |
| 8:30 | 4:30 | 12:30 |
| 8:45 | 4:45 | 12:45 |
| 9:00 | 5:00 | 1:00 |
| 9:15 | 5:15 | 1:15 |
| 9:30 | 5:30 | 1:30 |
| 9:45 | 5:45 | 1:45 |
| 10:00 | 6:00 | 2:00 |
| 10:15 | 6:15 | 2:15 |
| 10:30 | 6:30 | 2:30 |
| 10:45 | 6:45 | 2:45 |
| 11:00 | 7:00 | 3:00 |
| 11:15 | 7:15 | 3:15 |
| 11:30 | 7:30 | 3:30 |
| 11:45 | 7:45 | 3:45 |
| 12:00 | 8:00 | 4:00 |
| 12:15 | 8:15 | 4:15 |
| 12:30 | 8:30 | 4:30 |
| 12:45 | 8:45 | 4:45 |
| 1:00 | 9:00 | 5:00 |
| 1:15 | 9:15 | 5:15 |
| 1:30 | 9:30 | 5:30 |
| 1:45 | 9:45 | 5:45 |
| 2:00 | 10:00 | 6:00 |

Signatures

Signatures

Signatures

RECEIVED

JUL 30 2002

Charles Andrew

COL A. CAMPBELL

COL BROWN (RELIEF)

NO 10/12/02 0230

MEDICAL RECORDS DEPT

Utilize applicable codes listed on reverse side of form for behavior / treatment.

Date July 16, 2006
0600 - 1400Inmate Name PEAY, (2006)
1400 - 2200DC# DP 4246
2200 - 0600

| | | | | |
|-------|---------------|-------|--|-------|
| 6:00 | 10, 12 | 2:00 | | 10:00 |
| 6:15 | 10, 12, A, D | 2:15 | | 10:15 |
| 6:30 | 8, 12 | 2:30 | | 10:30 |
| 6:45 | 8, 12 | 2:45 | | 10:45 |
| 7:00 | 8, 12 | 3:00 | | 11:00 |
| 7:15 | 8, 12 | 3:15 | | 11:15 |
| 7:30 | 8, 12 | 3:30 | | 11:30 |
| 7:45 | 25, 6, E | 3:45 | | 11:45 |
| 8:00 | 10, 12 | 4:00 | | 12:00 |
| 8:15 | 10, 12 | 4:15 | | 12:15 |
| 8:30 | 10, 12 | 4:30 | | 12:30 |
| 8:45 | 10, 12 | 4:45 | | 12:45 |
| 9:00 | 10, 12 | 5:00 | | 1:00 |
| 9:15 | 10, 12 | 5:15 | | 1:15 |
| 9:30 | 10, 12, E | 5:30 | | 1:30 |
| 9:45 | 10, A | 5:45 | | 1:45 |
| 10:00 | 10, 12 | 6:00 | | 2:00 |
| 10:15 | 10, 12 | 6:15 | | 2:15 |
| 10:30 | 10, 12 | 6:30 | | 2:30 |
| 10:45 | Released to L | 6:45 | | 2:45 |
| 11:00 | | 7:00 | | 3:00 |
| 11:15 | | 7:15 | | 3:15 |
| 11:30 | | 7:30 | | 3:30 |
| 11:45 | | 7:45 | | 3:45 |
| 12:00 | | 8:00 | | 4:00 |
| 12:15 | | 8:15 | | 4:15 |
| 12:30 | | 8:30 | | 4:30 |
| 12:45 | | 8:45 | | 4:45 |
| 1:00 | | 9:00 | | 5:00 |
| 1:15 | | 9:15 | | 5:15 |
| 1:30 | | 9:30 | | 5:30 |
| 1:45 | | 9:45 | | 5:45 |
| 2:00 | | 10:00 | | 6:00 |

Signatures

Co. W. D. W. D. W. D.

Signatures

Signatures

Utilize applicable codes listed on reverse side of form for behavior / treatment.

Date 7-12-02Inmate Name WHITEDC# AH/Bx

0600 - 1400

1400 - 2200

2200 - 0600

| | | | |
|-------|------------|-------|-------|
| 6:00 | 10A, 13 | 2:00 | 10:00 |
| 6:15 | 10A, 13, A | 2:15 | 10:15 |
| 6:30 | | 2:30 | 10:30 |
| 6:45 | | 2:45 | 10:45 |
| 7:00 | | 3:00 | 11:00 |
| 7:15 | | 3:15 | 11:15 |
| 7:30 | | 3:30 | 11:30 |
| 7:45 | | 3:45 | 11:45 |
| 8:00 | | 4:00 | 12:00 |
| 8:15 | | 4:15 | 12:15 |
| 8:30 | | 4:30 | 12:30 |
| 8:45 | | 4:45 | 12:45 |
| 9:00 | | 5:00 | 1:00 |
| 9:15 | | 5:15 | 1:15 |
| 9:30 | | 5:30 | 1:30 |
| 9:45 | | 5:45 | 1:45 |
| 10:00 | | 6:00 | 2:00 |
| 10:15 | | 6:15 | 2:15 |
| 10:30 | | 6:30 | 2:30 |
| 10:45 | | 6:45 | 2:45 |
| 11:00 | | 7:00 | 3:00 |
| 11:15 | | 7:15 | 3:15 |
| 11:30 | | 7:30 | 3:30 |
| 11:45 | | 7:45 | 3:45 |
| 12:00 | | 8:00 | 4:00 |
| 12:15 | | 8:15 | 4:15 |
| 12:30 | | 8:30 | 4:30 |
| 12:45 | | 8:45 | 4:45 |
| 1:00 | | 9:00 | 5:00 |
| 1:15 | | 9:15 | 5:15 |
| 1:30 | | 9:30 | 5:30 |
| 1:45 | | 9:45 | 5:45 |
| 2:00 | | 10:00 | 6:00 |

Signatures

Signatures

Signatures

Utilize applicable codes listed on reverse side of form for behavior / treatment.

Date 8-21-02

Inmate Name S. PRAY

DC# DP4246

0600 - 1400

1400 - 2200

2200 - 0600

| | | | | | |
|-------|---------------------------|-------|-----------------------|-------|--|
| 6:00 | 10, EYES CLOSED | 2:00 | TALKING | 10:00 | |
| 6:15 | 10, EYES CLOSED | 2:15 | 10, TALKING | 10:15 | |
| 6:30 | 10, EYES CLOSED A | 2:30 | 10, TALKING | 10:30 | |
| 6:45 | 10, EYES CLOSED | 2:45 | 6, FAT 10 | 10:45 | |
| 7:00 | 10, EYES CLOSED | 3:00 | 12, 10 | 11:00 | |
| 7:15 | 10, EYES CLOSED | 3:15 | 12, 10 | 11:15 | |
| 7:30 | 10, EYES CLOSED | 3:30 | 12, 10 | 11:30 | |
| 7:45 | Visit by staff (Dr) Phys. | 3:45 | 12, 10 | 11:45 | |
| 8:00 | 10, EYES CLOSED | 4:00 | 12, 10 | 12:00 | |
| 8:15 | 10 " " | 4:15 | 12, 10 | 12:15 | |
| 8:30 | 10 " " | 4:30 | 10, 12 A E Sgt. Ayers | 12:30 | |
| 8:45 | 10 " " | 4:45 | 10, 12 | 12:45 | |
| 9:00 | 9, 11 | 5:00 | 10, 12 | 1:00 | |
| 9:15 | 9, 11 | 5:15 | 10, 12 | 1:15 | |
| 9:30 | 10, EYES CLOSED | 5:30 | | 1:30 | |
| 9:45 | 10 " " | 5:45 | | 1:45 | |
| 10:00 | 10 " " | 6:00 | | 2:00 | |
| 10:15 | 10 " " | 6:15 | | 2:15 | |
| 10:30 | 10 " " | 6:30 | | 2:30 | |
| 10:45 | 10 " " | 6:45 | | 2:45 | |
| 11:00 | 10 " " | 7:00 | | 3:00 | |
| 11:15 | 10 " " | 7:15 | | 3:15 | |
| 11:30 | 10 " " | 7:30 | | 3:30 | |
| 11:45 | 10 " " | 7:45 | | 3:45 | |
| 12:00 | 10 " " | 8:00 | | 4:00 | |
| 12:15 | 10 " " | 8:15 | | 4:15 | |
| 12:30 | 10 " " | 8:30 | | 4:30 | |
| 12:45 | 10 " " | 8:45 | | 4:45 | |
| 1:00 | 10 " " | 9:00 | | 5:00 | |
| 1:15 | 10 " " | 9:15 | | 5:15 | |
| 1:30 | 10 " " | 9:30 | | 5:30 | |
| 1:45 | 10 " " | 9:45 | | 5:45 | |
| 2:00 | 10 " " | 10:00 | | 6:00 | |

Signatures

Signatures

Signatures

Dr. Calman

JULIE S. ROBINSON
COT Tyler 1625

Utilize applicable codes listed on reverse side of form for behavior / treatment.

Date 8/20/02

Inmate Name

Peay FR SNYDC# DP-4246

0600 - 1400

1400 - 2200

TO
2004

2200 - 0600

| | | | | | |
|-------|---------------------------|-------|--------------------------|-------|--------|
| 6:00 | | 2:00 | 10, 12 | 10:00 | 10, 12 |
| 6:15 | | 2:15 | 10, 12 | 10:15 | 10, 12 |
| 6:30 | | 2:30 | 10, 12 | 10:30 | 11, 6 |
| 6:45 | | 2:45 | 10, 12 | 10:45 | 11, 6 |
| 7:00 | | 3:00 | 10, 12 | 11:00 | 11, 6 |
| 7:15 | | 3:15 | 10, 12 | 11:15 | 11, 6 |
| 7:30 | | 3:30 | 10, 12 | 11:30 | 10, 12 |
| 7:45 | | 3:45 | 10, 12 | 11:45 | 10, 12 |
| 8:00 | | 4:00 | 10, 12 | 12:00 | 10, 12 |
| 8:15 | | 4:15 | 10, 12 | 12:15 | 10, 12 |
| 8:30 | | 4:30 | 10, 6, A, E, C, T, Ashle | 12:30 | 10, 12 |
| 8:45 | | 4:45 | 10, 12 | 12:45 | 10, 12 |
| 9:00 | | 5:00 | 8, 6 | 1:00 | 10, 12 |
| 9:15 | | 5:15 | 10, 6 | 1:15 | 10, 12 |
| 9:30 | | 5:30 | 10, 6 | 1:30 | 10, 12 |
| 9:45 | | 5:45 | 10, 12 | 1:45 | 10, 12 |
| 10:00 | | 6:00 | 11, 6 | 2:00 | 10, 12 |
| 10:15 | | 6:15 | 11, 6 | 2:15 | 10, 12 |
| 10:30 | | 6:30 | 11, 12 | 2:30 | 10, 12 |
| 10:45 | 6, E (Nurse Mark), 10, 12 | 6:45 | 11, 12 | 2:45 | 10, 12 |
| 11:00 | 10, 12 | 7:00 | 9, 12, D. | 3:00 | 10, 12 |
| 11:15 | 10, 12 | 7:15 | 18, 8, 6 | 3:15 | 10, 12 |
| 11:30 | 10, 12 | 7:30 | 11, 12 | 3:30 | 10, 12 |
| 11:45 | 10, 12 | 7:45 | 11, 12 | 3:45 | 10, 12 |
| 12:00 | 10-12 | 8:00 | 11, 12 | 4:00 | 10, 12 |
| 12:15 | 10-12 | 8:15 | 11, 12 | 4:15 | 10, 22 |
| 12:30 | 10-12 | 8:30 | 11, 6 | 4:30 | 10, 33 |
| 12:45 | 10-12 | 8:45 | 11, 6 | 4:45 | 10, 12 |
| 1:00 | 10-12 | 9:00 | 11, 6 | 5:00 | 10, 12 |
| 1:15 | 10-12 | 9:15 | 10, 6 | 5:15 | 10, 12 |
| 1:30 | 10-12 | 9:30 | 10, 12 | 5:30 | 10, 12 |
| 1:45 | 10-12 | 9:45 | 10, 12 | 5:45 | 10, 12 |
| 2:00 | 10-12 | 10:00 | 10, 12 | 6:00 | 10, 12 |

Signatures

Signatures

Signatures

Col De San 1045
Col DA Morn 1200

1405
Col Tyler 4:00pm

Col E. J. SMORE

Utilize applicable codes listed on reverse side of form for behavior / treatment.

MENTAL STATUS REVIEW/CONTACT NOTE

INMATE PAYDC# DP 4246STAFF C Joseph PSSDATE 2/15/02

| | | | NOT PRESENT | SLIGHT | MARKED |
|--|------------------------------------|--|----------------|--------|--------|
| APPEARANCE | | Uncleanliness: of person of cell of clothing | <u>✓</u> | | |
| BEHAVIOR | Doctor-Patient Relation ship | domineering suspicious uncooperative | <u>✓</u> | | |
| FEELING | (Affect and Mood) | blunted sad hostile anxious | <u>✓</u> | | |
| PERCEPTION | | illusions hallucinations | <u>✓</u> | | |
| RECEIVED THINKING FEB 14 2002 | Insight | difficulty in acknow- ledging the presence of psychological problems. mostly blames others or circumstances for problems | <u>✓</u> | | |
| | Judgement | impaired ability to manage daily living activities. impaired ability to make reasonable life decisions. | <u>✓</u> | | |
| | Thought Content | compulsions suicidal ideation homicidal ideation | <u>✓</u> | | |

COMMENTS: MR. Pay was asking to get a Sargent to talk to him something important. Offered him psychological help. He is denied of having psychological problem. He is not active on mental health main frame either. MR. Pay is negative of any major psychopathology needs psychological help at this time. Informed Sgt. on New about inmates request to talk to him.

C Joseph PSS.

INMATE NAME:

Stanton Ray

DOC #:

DP41246

RHU Officer completing form (print):

Lt. K.C. Jones

Date:

7-25-99

Time:

0925

RECEIVED

AUG 17 1999

MEDICAL
SCI Unit EnrORD DEPT.

1. Escorting officer has information that inmate may be a suicidal risk.
2. Inmate is expressing suicidal thoughts / making threats to harm self.
3. Inmate shows signs of depression (crying, withdrawn, passive).
4. Inmate is acting / talking in a strange manner (hearing / seeing things that aren't there).
5. Inmate appears to be under the influence of drugs / alcohol.
6. Inmate has recent family change (e.g., death of child/spouse/parent or "Dear John Letter").
7. Inmate has recent legal status change (e.g., parole violation or new detainee).
8. Inmate has been assaulted (physically or sexually) by another inmate.
9. Inmate shows anger, hostility, and threats.
10. Inmate appears anxious, afraid (pacing, wringing hands).
11. Inmate displays signs of self-neglect or abuse (e.g., poor hygiene or cuts and bruises).
12. Inmate states this is his / her first placement in RHU.
13. Inmate states that he / she is taking psychiatric medication.

Comments:

Instructions: The ranking CO present shall ensure that this form is completed when an inmate is brought to the RHU. The escorting officer will be asked (a) why the inmate is being brought in and (b) whether there is any information that the inmate may be self-destructive. The inmate will be asked (a) if this is his / her first time in the RHU, (b) if he / she has any special problems or needs of which staff should be aware, (c) if he / she is on any medication, and/or (d) whether he / she has any recent legal status changes (e.g., Parole violation, detainees). The officer will also note any special physical / behavioral characteristics (e.g., crying, poor hygiene, cuts & bruises) or if the inmate is uncooperative.

If any of items #1 through #7 are checked "Yes", the RHU officer shall immediately phone the following staff:

- Between 8:00 a.m. and 4:30 p.m., nursing and Chief Psychologist or MHC. Psychologist will immediately visit the RHU and review the checklist, assess the inmate, and discuss the case with RHU staff. Time of assessment will be recorded on form.
- After hours, or on weekends, the nursing staff and Shift Commander. Nurse will immediately visit RHU to review the checklist, assess the inmate, and discuss case with RHU staff. Time of assessment will be recorded on form.
- At any time the inmate appears in immediate danger of harming him / herself or somebody else, the RHU staff shall also contact the Shift Commander, as well as nursing staff and Chief Psychologist or MHC to request an immediate assessment.

If any of items #8 through #13 are checked, the form will be submitted to the nurse and / or psychologist the next time they visit the RHU, but within 24 hours. The nurse or psychologist will assess the inmate and note the date and time of assessment. The completed form will remain in the Cumulative Adjustment Record until reviewed by PRC. Copies to Medical Records and DC-14.

Clinical Staff Action:

Date:

Time:

Name of Clinical staff (printed):

Title:

S. PEAY
 INMATE NAME: _____ DOC #: DP 4246
 RHU/SMU Officer Completing Form (print): CO-M. A LOPEZ Date: 2-13-99 Time: 2/25

- Y ☒ N ☐ 1. Escorting officer has information that inmate may be a suicidal risk.
- Y ☒ N ☐ 2. Inmate is expressing suicidal thoughts/making threats to harm self.
- Y ☒ N ☐ 3. Inmate shows signs of depression (crying, withdrawn, passive).
- Y ☒ N ☐ 4. Inmate is acting/talking in a strange manner (hearing/seeing things that aren't there).
- Y ☒ N ☐ 5. Inmate appears to be under the influence of drugs/alcohol.
- Y ☒ N ☐ 6. Inmate has recent family change (e.g., death of child/spouse/parent or "Dear John letter").
- Y ☒ N ☐ 7. Inmate has recent legal status change (e.g., parole violation or new detainer).
- Y ☒ N ☐ 8. Inmate has been assaulted (physically or sexually) by another inmate.
- Y ☒ N ☐ 9. Inmate shows anger, hostility, and threats.
- Y ☒ N ☐ 10. Inmate appears anxious, afraid (pacing, wringing hands).
- Y ☒ N ☐ 11. Inmate displays signs of self-neglect or abuse (e.g., poor hygiene or cuts and bruises).
- Y ☒ N ☐ 12. Inmate states this is his/her first placement in RHU/SMU.
- Y ☒ N ☐ 13. Inmate states that he/she is taking psychiatric medication.

Comments:

Instructions: The ranking CO present shall ensure that this form is completed when an inmate is brought to the RHU/SMU. The escorting officer will be asked (a) why the inmate is being brought in and (b) whether there is any information that the inmate may be self-destructive. The inmate will be asked (a) if this is his/her first time in the RHU/SMU, (b) if he/she has any special problems or needs of which staff should be aware, (c) if he/she is on any medication, and (d) whether he/she has any recent legal status changes (e.g., Parole violation or detainer). The officer will also note any special physical/behavioral characteristics (e.g., crying, poor hygiene, and cuts & bruises) or if the inmate is uncooperative.

If any of items #1 through #7 are checked "Yes," the RHU/SMU officer shall immediately phone the following staff:

- ☐ Between 8:00 AM and 4:30 PM, nursing and Chief Psychologist or MHC. Psychologist will immediately visit the RHU/SMU to review the checklist, assess the inmate, and discuss the case with RHU/SMU staff. Time of assessment will be recorded on form.
- ☐ After hours, or on weekends, the nursing staff and Shift Commander. Nurse will immediately visit RHU/SMU to review checklist, assess the inmate, and discuss case with RHU/SMU staff. Time of assessment will be recorded on form.
- ☐ At any time the inmate appears in immediate danger of harming him/herself or somebody else, the RHU/SMU staff shall also contact the Shift Commander, as well as nursing staff and Chief Psychologist or MHC to request an immediate assessment.

If any of items #8 through #13 are checked, the form will be submitted to the nurse and/or psychologist the next time they visit the RHU/SMU, but within 24 hours. The nurse or psychologist will assess the inmate and note the date and time of assessment. The completed form will remain in the Cumulative Adjustment Record until reviewed by PRC. Copies to Medical Record & DC-14.

Clinical Staff Action: _____ Date: _____ Time: _____
 Name of Clinical staff (printed): _____ Title: _____

SUICIDE RISK INDICATORS CHECKLIST FOR RHU's

5/98

INMATE NAME: S. Peay DOC #: DP4246RHU Officer Completing Form (print): R. HILTON COIT Date: 10/23/98 Time: 1044

- Y ☒ 1. Escorting officer has information that inmate may be a suicidal risk.
- Y ☒ 2. Inmate is expressing suicidal thoughts/making threats to harm self.
- Y ☒ 3. Inmate shows signs of depression (crying, withdrawn, passive).
- Y ☒ 4. Inmate is acting/talking in a strange manner (hearing/seeing things that aren't there).
- Y ☒ 5. Inmate appears to be under the influence of drugs/alcohol.
- Y ☒ 6. Inmate has recent family change (e.g., death of child/spouse/parent or "Dear John letter").
- Y ☒ 7. Inmate has recent legal status change (e.g., parole violation or new detainee).
- Y ☒ 8. Inmate has been assaulted (physically or sexually) by another inmate.
- Y ☒ 9. Inmate shows anger, hostility, and threats.
- Y ☒ 10. Inmate appears anxious, afraid (pacing, wringing hands).
- Y ☒ 11. Inmate displays signs of self-neglect or abuse (e.g., poor hygiene or cuts and bruises).
- Y ☒ 12. Inmate states this is his/her first placement in RHU.
- Y ☒ 13. Inmate states that he/she is taking psychiatric medication.

Comments:

Instructions: The ranking CO present shall ensure that this form is completed when an inmate is brought to the RHU. The escorting officer will be asked (a) why the inmate is being brought in and (b) whether there is any information that the inmate may be self-destructive. The inmate will be asked (a) if this is his/her first time in the RHU, (b) if he/she has any special problems or needs of which staff should be aware, (c) if he/she is on any medication, and/or (d) whether he/she has any recent legal status changes (e.g., Parole violation, detainee). The officer will also note any special physical/behavioral characteristics (e.g., crying, poor hygiene, cuts & bruises) or if the inmate is uncooperative.

If any of items #1 through #7 are checked "Yes," the RHU officer shall immediately phone the following staff:

- > Between 8:00 AM and 4:30 PM, nursing and Chief Psychologist or MHC. Psychologist will immediately visit the RHU to review the checklist, assess the inmate, and discuss the case with RHU staff. Time of assessment will be recorded on form.
- > After hours, or on weekends, the nursing staff and Shift Commander. Nurse will immediately visit RHU to review checklist, assess the inmate, and discuss case with RHU staff. Time of assessment will be recorded on form.
- > At any time the inmate appears in immediate danger of harming him/herself or somebody else, the RHU staff shall also contact the Shift Commander, as well as nursing staff and Chief Psychologist or MHC to request an immediate assessment.

If any of items #8 through #13 are checked, the form will be submitted to the nurse and/or psychologist the next time they visit the RHU, but within 24 hours. The nurse or psychologist will assess the inmate and note the date and time of assessment. The completed form will remain in the Cumulative Adjustment Record until reviewed by PRD. Copies to Medical Records and DC-14.

Clinical Staff Action: none taken

Date: 10/23/98 Time: 1700 Signature: Monica R. Smith Title: 11/15/98

SUICIDE RISK INDICATORS CHECKLIST FOR RHU's

5/98

INMATE NAME: PEAY DOC #: DP 4246RHU Officer Completing Form (print): L. VICKENS Date: 9-23-98 Time: 10:05

- Y ☒ N 1. Escorting officer has information that inmate may be a suicidal risk.
- Y ☒ N 2. Inmate is expressing suicidal thoughts/making threats to harm self.
- Y ☒ N 3. Inmate shows signs of depression (crying, withdrawn, passive).
- Y ☒ N 4. Inmate is acting/talking in a strange manner (hearing/seeing things that aren't there).
- Y ☒ N 5. Inmate appears to be under the influence of drugs/alcohol.
- Y ☒ N 6. Inmate has recent family change (e.g., death of child/spouse/parent or "Dear John letter").
- Y ☒ N 7. Inmate has recent legal status change (e.g., parole violation or new detainee).
- Y ☒ N 8. Inmate has been assaulted (physically or sexually) by another inmate.
- Y ☒ N 9. Inmate shows anger, hostility, and threats.
- Y ☒ N 10. Inmate appears anxious, afraid (pacing, wringing hands).
- Y ☒ N 11. Inmate displays signs of self-neglect or abuse (e.g., poor hygiene or cuts and bruises).
- Y ☒ N 12. Inmate states this is his/her first placement in RHU.
- Y ☒ N 13. Inmate states that he/she is taking psychiatric medication.

Comments:

Instructions: The ranking CO present shall ensure that this form is completed when an inmate is brought to the RHU. The escorting officer will be asked (a) why the inmate is being brought in and (b) whether there is any information that the inmate may be self-destructive. The inmate will be asked (a) if this is his/her first time in the RHU, (b) if he/she has any special problems or needs of which staff should be aware, (c) if he/she is on any medication, and/or (d) whether he/she has any recent legal status changes (e.g., Parole violation, detainee). The officer will also note any special physical/behavioral characteristics (e.g., crying, poor hygiene, cuts & bruises) or if the inmate is uncooperative.

If any of items #1 through #7 are checked "Yes," the RHU officer shall immediately phone the following staff:

- > Between 8:00 AM and 4:30 PM, nursing and Chief Psychologist or MHC. Psychologist will immediately visit the RHU to review the checklist, assess the inmate, and discuss the case with RHU staff. Time of assessment will be recorded on form.
- > After hours, or on weekends, the nursing staff and Shift Commander. Nurse will immediately visit RHU to review checklist, assess the inmate, and discuss case with RHU staff. Time of assessment will be recorded on form.
- > At any time the inmate appears in immediate danger of harming him/herself or somebody else, the RHU staff shall also contact the Shift Commander, as well as nursing staff and Chief Psychologist or MHC to request an immediate assessment.

If any of items #8 through #13 are checked, the form will be submitted to the nurse and/or psychologist the next time they visit the RHU, but within 24 hours. The nurse or psychologist will assess the inmate and note the date and time of assessment. The completed form will remain in the Cumulative Adjustment Record until reviewed by PRC. Copies to Medical Record & DC-14

Clinical Staff Action: Assessed @ cell, & complaining. Demanding medical attention for cuts not band, which has been bleeding since treatment today. Whining, obsessive, no self-destructive complaints.

Date: 9/23 Time: 1:35 Name of Clinical staff (printed): Terold Hurwitz Title: PSS

RECEIVED
Right hand of inmate
9/23/98
SCI GRATERFORD

Person Preparing Report

PEAY, STRATTON
DP-4246

13. PSYCHIATRIC HISTORY:

None indicated in available records as of 5/19/98.

14. PSYCHOLOGICAL REPORT:

Tests Administered: All tests were administered on 5/19/98.

Revised Beta II Examination (RBE)
Jastak Wide Range Achievement Test (WRAT3)

| | | | |
|----------------------|------------|---------|----------|
| Reading Score: 47 | St.Sc. 101 | %ile 53 | G.E.12.8 |
| Spelling Score: 43 | St.Sc. 103 | %ile 38 | G.E.11.3 |
| Arithmetic Score: 38 | St.Sc. 89 | %ile 23 | G.E. 7 |

Bender Motor Gestalt (BMG)
Projective Drawings (HTP)
Personality Assessment Inventory (PAI)

Analysis of Intelligence and Intellectual Functioning:

Mr. Peay earned a Beta Quotient of 97. This score falls within the Average range of mental ability according to the Beta II classification. The obtained rating is viewed as a reasonably accurate estimate of his intellectual potential.

Analysis of Personality Makeup:

Current test data and interview impression are not reflective of significant psychopathology requiring immediate psychiatric intervention. Indications are of a self-centered, evasive, immature and impulsive individual who is apt to possess a low tolerance for frustration. He is prone to exercise poor judgement as he strives for immediate gratification of his desires without adequate regard for the consequences of his actions to himself or to others. Indications of underlying resentment and hostility creates a potential for acting out behaviors. He appears to place blame for his actions externally and because of this, his motivation for treatment may be low. Interpersonally, his relationships seem to be superficial due to his apparent suspiciousness and resentment of others.

Prognosis for institutional adjustment is guarded. This is Mr. Peay's first state incarceration. As such, he may be vulnerable to more experienced inmates. Participation in ABE/vocational programs, substance abuse counseling and stress/anger management counseling is recommended. Close supervision is advised until a stable adjustment pattern has been established.

W. Hals
Psychologist
Licensed #PS008062-L

/bac

BIO-REFERENCE LABORATORIES481 EDWARD H. ROSS DR.
ELMWOOD PARK, N.J. 07407

201-791-3600

1-800-229-LABS

| | | | | |
|-------------------------|--|-----------------------------------|------------------------------------|--------------------------------------|
| DOCTOR | SCI GRATERFORD/PHS GRAVEL PIKE AND BRIDGE GRATERFORD, PA 19426 | | | |
| | (P0055-6) Bio-Net Print | | -FINAL- Original Report 06/13/2002 | |
| NAME PEAY, STRATTON | | PATIENT I.D. / ROOM NO. DP4246 | | DOCTOR / GROUP NAME DR. IACCARINO |
| LAB ID NO. 103417777 | | DATE COLLECTED 06/12/2002 | DATE RECEIVED 06/12/2002 23:33 | DATE OF REPORT 6/13/2002 10:21 |
| | | AGE 25 | SEX M | |

| Test Description | Result | Abnormal | Reference Range |
|------------------|--------|----------|-----------------|
|------------------|--------|----------|-----------------|

Tests Ordered : PANEL 2052, ,

* CHEMISTRY *

| | | | | |
|-------------------------|------|--------|-----------|--------|
| TOTAL PROTEIN | 8.4 | | 5.9-8.4 | gm/dl |
| ALBUMIN | 5.0 | | 3.2-5.2 | gm/dl |
| GLOBULIN | 3.4 | | 1.7-3.7 | gm/dl |
| A/G RATIO | 1.5 | | 1.1-2.9 | UNITS |
| GLUCOSE | 79 | | 70-109 | mg/dL |
| SODIUM | 141 | | 133-145 | mEq/L |
| POTASSIUM | 3.8 | | 3.3-5.1 | mEq/L |
| CHLORIDE | 101 | | 96-108 | mmol/L |
| CO2 | 28 | | 22-29 | mmol/L |
| BUN | 7 | | 7-25 | mg/dl |
| CREATININE | 0.9 | 7.8 LO | 0.4-1.2 | mg/dl |
| BUN/CREAT RATIO | | | 10-28 | UNITS |
| CALCIUM | 9.7 | | 8.4-10.2 | mg/dl |
| URIC ACID | 4.6 | | 2.4-7.0 | mg/dl |
| IRON | 102 | | 30-160 | mcg/dl |
| BILIRUBIN, TOTAL | 0.6 | | 0.0-1.0 | mg/dl |
| LDH | 130 | | 94-250 | u/l |
| ALK PHOS | 58 | | 39-120 | u/l |
| AST (SGOT) | 17 | | 37 | u/l |
| PHOSPHOROUS | 3.6 | | 2.6-4.5 | mg/dl |
| ALT (SGPT) | 16 | | < 40 | u/L |
| G-GTP | 34 | | 7-51 | u/L |
| CHOLESTEROL | 143 | | < 200 | mg/dl |
| TRIGLYCERIDES | 85 | | < 200 | mg/dl |
| HDL CHOL., DIRECT | 46 | | >45F/>35M | mg/dL |
| HDL AS % OF CHOLESTEROL | 32 | | SEE BELOW | % |
| CHOL/HDL RATIO | 3.11 | | SEE BELOW | |
| LDL/HDL RATIO | 1.74 | | 0-3.55 | MG/DL |
| LDL CHOLESTEROL | 80 | | < 130 | mg/dL |

RECEIVED

JUN 17 2002

MEDICAL RECORDS DEPT.
SCI GRATERFORD

Diagnostic Reports

Name: PEAY, STRATTONDate / Time: 6/13/02 16:00

A

N

NCS

| | | | |
|----------------|---|-------------------------|-----------------------|
| % HDL: (M & F) | * | CHOL/HDL: Male / Female | |
| > 25 | | < 4.2 < 3.9 | BELOW AVERAGE RISK |
| 15-25 | | 4.2-7.3 3.9-5.7 | AVERAGE RISK |
| 9-15 | | 7.4-11.5 5.8-9.0 | ABOVE AVG. (MODERATE) |
| < 9 | | > 11.5 > 9.0 | ABOVE AVG. (HIGH) |

* HEMATOLOGY *

WBC

3.4

3.4-11.8 x10(3

Continued on Next Page

BIO-REFERENCE LABORATORIES481 EDWARD H. ROSS DR.
ELMWOOD PARK, N.J. 07407

201-791-3600

1-800-229-LABS

| | | | | |
|----------------------------|--|-----------------------------------|------------------------------------|--------------------------------------|
| D O C T O R | SCI GRATERFORD/PHS GRAVEL PIKE AND BRIDGE GRATERFORD, PA 19426 | | | |
| | (P0055-6) Bio-Net Print | | -FINAL- Original Report 06/13/2002 | |
| NAME PEAY, STRATTON | | PATIENT I.D. / ROOM NO. DP4246 | | DOCTOR / GROUP NAME DR. IACCARINO |
| LAB I.D. NO. 103417777 | DATE COLLECTED 06/12/2002 | DATE RECEIVED 06/12/2002 23:33 | DATE OF REPORT 6/13/2002 10:21 | AGE 25 SI M |

| Test Description | Result | Abnormal | Reference Range |
|--------------------|--------|----------|-----------------|
| RBC | 4.9 | | 4.2-5.9 x10(6) |
| HGB | 15.3 | | 12.3-17.0 gm/dl |
| HCT | 44.6 | | 39.3-52.5 % |
| MCV | 91.0 | | 79.2-104.1 |
| MCH | 31.2 | | 25-34.1 pg |
| MCHC | 34.3 | | 30-34.4 gm/dl |
| RDW | 13.7 | | 10.9-16.9 % |
| POLYS | | 32 LO | 36.0-78.0 % |
| POLYS - COUNT,ABS | | 1.088 LO | 1.2-9.2 x10(3) |
| LYMPHS | | 55 HI | 12.0-48.0 % |
| LYMPHS - COUNT,ABS | 1.870 | | 4-5.6 x10(3) |
| EOS | 4 | | % |
| EOS - COUNT,ABS | 0.136 | | 0.3-1.0 x10(3) |
| BASOS | 0 | | 0-2 % |
| BASOS - COUNT,ABS | 0.000 | | 0-.07 x10(3) |
| MONOS | 9 | | 5-12 % |
| MONOS - COUNT,ABS | 0.306 | | .2-1.4 x10(3) |
| PLATELET COUNT | 226 | | 144-400 x10(3) |
| * MISCELLANEOUS * | | | |

| | | |
|---------------------|-------|----------------|
| THY.STIM.HORM.(TSH) | 0.716 | 0.27-4.2uIU |
| THYROXINE(T4) | 7.2 | 4.0-12.0 ug/dL |
| T3 UPTAKE | 33 | 25-35% |
| FREE T4 INDEX | 2.4 | 1.1-4.5 |

NOTE: EFFECTIVE 8/15/01, the 3rd.generation TSH assay (1343) is being performed under test code 0153 (thyroid stimulating hormone). This is a new assay with improved low-end sensitivity, however there will be no change in reference range.

Final Report

BIO-REFERENCE LABORATORIES

201-791-3600

1-800-229-LABS

| | | | | |
|----------------------------|--|-----------------------------------|---|-----------------------------------|
| D O C T O R | SCI GRATERFORD/PHS GRAVEL PIKE AND BRIDGE GRATERFORD, PA 19426 | | | |
| | (P0055-6) Bio-Net Print | | -FINAL- Original Report 04/25/2002 | |
| | NAME PEAY, STEATTON | PATIENT I.D. / ROOM NO. DP4246 | DOCTOR / GROUP NAME SCI GRATERFORD/PHS | |
| | LAB I.D. NO. 103183069 | DATE COLLECTED 04/24/2002 | DATE RECEIVED 04/24/2002 23:09 | DATE OF REPORT 4/26/2002 07:31 |
| | | AGE 25 | SEX M | |

| Test Description | Result | Abnormal | Reference Range |
|------------------|--------|----------|-----------------|
|------------------|--------|----------|-----------------|

Tests Ordered : GAMMA-GT (G-GTP), RPR SEROLOGY, ,

* CHEMISTRY *

| | | | |
|-------|----|------|-----|
| G-GTP | 51 | 7-51 | u/L |
|-------|----|------|-----|

* MISCELLANEOUS *

| | | |
|-----|------------|--------------|
| RPR | Non-Reacti | NON-REACTIVE |
|-----|------------|--------------|

RPR INTERPRETATION:

Low-titer positive RPRs up to approximately 1:8 are usually caused by other, non-specific constituents and are not usually caused by the disease. Confirmation of positive RPRs can only be made by the Serodia-tp confirmation test.

Final Report

RECEIVED
APR 29 2002
MEDICAL RECORDS DEPT.
SCI GRATERFORD

RALPH W. SMITH, MD
Diagnostic Reports
MEDICAL DOCTOR

Name: [Signature]
Date / Time: 4/26/02 06:30
A (N) NCS

201-791-3600

1-800-229-LABS

| | | | | |
|------------------------|--|-----------------------------------|------------------------------------|---------------------------------|
| DOCTOR | SCI GRATERFORD/PHS GRAVEL PIKE AND BRIDGE GRATERFORD, PA 19426 | | -FINAL- Original Report 08/30/2001 | |
| | (P0055-6) Bio-Net Print | | | |
| NAME PEAY, STRATTON | | PATIENT I.D. / ROOM NO. DP4246 | DR. D. DENNIS IACCARINO | |
| 102164763 | | 08/27/2001 COLLECTED | 08/29/2001 23:56 RECEIVED | 08/30/2001 02:20 DATE OF REPORT |
| Test Description | | Result | Abnormal | Reference Range |

Tests Ordered : CH24/HDL, CBC W/DIFF, PLATELET CT., URINALYSIS, COMPLETE, LIPASE, AMYLASE, ,

Comment : 08-27-01

* CHEMISTRY *

| | | | | |
|-------------------------|------|---------------------------------|-----------|--------|
| TOTAL PROTEIN | 8.2 | DENNIS IACCARINO D.O. | 5.9-8.4 | gm/dl |
| ALBUMIN | 5.0 | PHS PHYSICIAN | 3.2-5.2 | gm/dl |
| GLOBULIN | 3.2 | | 1.7-3.7 | gm/dL |
| A/G RATIO | 1.6 | | 1.1-2.9 | UNITS |
| GLUCOSE | 89 | | 70-109 | mg/dL |
| SODIUM | 140 | Name: <u>Stratton</u> | 133-145 | mEq/L |
| POTASSIUM | 4.3 | Date / Time: <u>9/4/01 1300</u> | 3.3-5.1 | mEq/L |
| CHLORIDE | 101 | A N (NCS) | 96-108 | mmol/L |
| CO2 | 27 | | 22-29 | mmol/L |
| BUN | 7 | | 7-25 | mg/dl |
| CREATININE | 0.9 | | 0.4-1.2 | mg/dl |
| BUN/CREAT RATIO | | 7.8 LO | 10-28 | UNITS |
| CALCIUM | 9.3 | | 8.4-10.2 | mg/dl |
| URIC ACID | 3.8 | | 2.4-7.0 | mg/dl |
| IRON | 73 | | 30-160 | mcg/dl |
| BILIRUBIN, TOTAL | 0.3 | | 0.0-1.0 | mg/dl |
| LDH | 172 | | 94-250 | u/l |
| ALK PHOS | 57 | | 39-120 | u/l |
| AST (SGOT) | 20 | | < 37 | u/l |
| PHOSPHOROUS | 2.6 | | 2.6-4.5 | mg/dl |
| ALT (SGPT) | 20 | | < 40 | u/L |
| G-GTP | 42 | | 7-51 | u/L |
| CHOLESTEROL | 142 | | < 200 | mg/dl |
| TRIGLYCERIDES | 63 | | < 200 | mg/dl |
| HDL CHOL., DIRECT | 50 | | >45F/>35M | mg/dL |
| HDL AS % OF CHOLESTEROL | 35 | | SEE BELOW | % |
| CHOL/HDL RATIO | 2.84 | | SEE BELOW | |
| LDL/HDL RATIO | 1.6 | | 0-3.55 | MG/DL |
| LDL CHOLESTEROL | 80 | | < 130 | mg/dL |

| | | |
|----------------|---------------------------|-----------------------|
| % HDL: (M & F) | * CHOL/HDL: Male / Female | |
| > 25 | < 4.2 < 3.9 | BELOW AVERAGE RISK |
| 15-25 | 4.2-7.3 3.9-5.7 | AVERAGE RISK |
| 9-15 | 7.4-11.5 5.8-9.0 | ABOVE AVG. (MODERATE) |
| < 9 | > 11.5 > 9.0 | ABOVE AVG. (HIGH) |

Continued on Next Page

Robert L. Rush P.H.

201-791-3600

1-800-229-LABS

D
O
C
T
O
R

SCI GRATERFORD/PHS
 GRAVEL PIKE AND BRIDGE
 GRATERFORD, PA 19426

(P0055-6) Bio-Net, Print

-FINAL- Original Report 08/30/2001

PEAY, STRATTON

DP4246

PATIENT I.D. / ROOM NO.

DR. D. IACCARINO

102164763

08/27/2001

08/29/2001

13:56

8/30/2001 02:20 24 AGE M_{SE}

Test Description

Result

Abnormal

Reference Range

* HEMATOLOGY *

WBC
 RBC
 HGB
 HCT
 MCV
 MCH
 MCHC
 RDW
 POLYS
 POLYS - COUNT, ABS
 LYMPHS
 LYMPHS - COUNT, ABS
 EOS
 EOS - COUNT, ABS
 BASOS
 BASOS - COUNT, ABS
 MONOS
 MONOS - COUNT, ABS
 PLATELET COUNT

5.0
 15.0
 45.2
 90.9
 30.2
 33.2
 14.2

Diagnostic Reports

Name: DR. IACCARINO D.O.

Date / Time: 8/4/01 1200

A

N

NCS

24 LO
 0.576 LO
 59 HI

3.4-11.8 x10(3)
 4.2-5.9 x10(6)
 12.3-17.0 gm/dl
 39.3-52.5 %
 79.2-104.1
 25-34.1 pg
 30-34.4 gm/dl
 10.9-16.9 %
 36-78 %
 1.2-9.2 x10(3)
 12-48 %
 .4-5.6 x10(3)
 1-8 %
 .03-1.0 x10(3)
 0-2 %
 0-.07 x10(3)
 5-12 %
 .2-1.4 x10(3)
 144-400 x10(3)

* URINALYSIS *

COLOR/APPEARANCE
 SPECIFIC GRAVITY
 PH
 PROTEIN, URINE
 GLUCOSE, URINE, QUAL.
 KETONE, QUAL.
 UROBILINOGEN
 BILIRUBIN, URINE
 BLOOD, URINE
 NITRITES
 LEU. ESTERASE
 WBC, URINE
 RBC, URINE
 EPITHELIAL CELLS, URINE
 CAST, HYALINE, URINE
 CAST, GRANULAR, URINE
 CAST, RBC, URINE
 BACTERIA, URINE

Yellow/Clear
 1.010
 7.000
 NEGATIVE
 NEGATIVE
 NEGATIVE
 0.2
 NEGATIVE
 NEGATIVE
 NEGATIVE
 NEGATIVE
 NONE
 NONE
 NONE
 NONE
 NONE
 NONE

STRAW/CLEAR
 1.000-1.050
 5.0-9.0
 NEGATIVE
 NEGATIVE
 NEGATIVE
 0-2 UNITS
 NEGATIVE
 NEGATIVE
 NEGATIVE
 NEGATIVE
 0-3 PER H
 0-1 PER H
 0-9 U
 NONE U
 NONE U
 NONE U
 NONE U
 NONE U

OCCASIONAL

Continued on Next Page

Robert L. Rush Ph.

201-791-3600

1-800-229-LABS

DOCTOR

SCI GRATERFORD/PHS
GRAVEL PIKE AND BRIDGE
GRATERFORD, PA 19426

(P0055-6) Bio-Net Print

-FINAL- Original Report 08/30/2001

PEAY, STRATTON

DP4246

PATIENT I.D. / ROOM NO.

DR. D. IACCARINO

102164763

08/27/2001 COLLECTED

08/29/2001 23:56 RECEIVED

8/30/2001 02:20 DATE OF REPORT

AGE

SEX

Test Description

Result

Abnormal

Reference Range

MUCUS, URINE
AMYLASE, SERUM
LIPASE, SERUM

NONE
67
55

SMALL AMOUNT
<100 U/L
0-190 U/L

Final Report

DENNIS IACCARINO D.O.
PHS PHYSICIAN

Diagnostic Reports

Name: [Signature]

Date / Time: 9/4/01 1300

A

N

NCS

Robert L. Rush P.H.L.

BIO-REFERENCE LABORATORIES461 EDWARD H. ROSS DR.
ELMWOOD PARK, N.J. 07407

201-791-3600

1-800-229-LABS

| | | | | |
|----------------------------|--|-----------------------------------|-------------------------------------|---|
| D O C T O R | SCI GRATERFORD/PHS GRAVEL PIKE AND BRIDGE GRATERFORD, PA 19426 | | | |
| | (P0055-6) Bio-Net Print | | -FINAL- Original Report 07/19/2001 | |
| | NAME PEAY, S | PATIENT I.D. / ROOM NO. DP4246 | DOCTOR / GROUP NAME DR. AKBERZIE | |
| | LAB ID NO. 101966525 | DATE COLLECTED 07/17/2001 | DATE RECEIVED 07/17/2001 22:39 | DATE OF REPORT 7/19/2001 04:01 24 AGE 24 SEX M |

| Test Description | Result | Abnormal | Reference Range |
|------------------|--------|----------|-----------------|
|------------------|--------|----------|-----------------|

Tests Ordered : H. PYLORI ANTIBODY PANEL, ,

H.PYLORI AB., IGG
H.PYLORI AB., IGA
H.PYLORI AB., IGM

0.23
0.11
0.77

SEE BELOW
SEE BELOW
SEE BELOW

H.PYLORI (IgG, IgA, IgM) REFERENCE RANGES: (previous ranges)

| | | |
|-----------|-----------------|-----------------|
| NEGATIVE | <0.89 UNITS | <12.6 units |
| EQUIVOCAL | 0.89-0.99 UNITS | 12.6-20.0 units |
| POSITIVE | >0.99 UNITS | >20.0 units |

NOTE: This is a screening test for H.PYLORI and the diagnosis of gastritis and peptic ulcers should be assessed with the patients medical history and clinical symptoms. Results in the equivocal range should be rechecked with a new specimen in 2-5 weeks.

NOTE: H.Pylori Antibody, IgA (test#1766) is for RESEARCH USE ONLY.
This assay is NOT for use in Diagnostic Procedures.

Final Report

RALPH W SMITH MD

Diagnostic Reports

Name: Date / Time: 7/20/01 1410

A

N

NCS

RECEIVED

JUL 23 2001

MEDICAL RECORDS DEPT.
SCI GRATERFORD

Robert L. Rush Ph.D.

LABORATORY CORPORATION OF AMERICA

| | | | | |
|--------------------------------|--------------|-----------------------------|-----------------------------|----------------------|
| SPECIMEN 313-142-3262-0 | TYPE S | PRIMARY LAB RN | REPORT STATUS COMPLETE | Page #: 1 |
| ADDITIONAL INFORMATION | | | | |
| BEKER DOB: 11/04/1976 | | | | |
| PATIENT NAME PEAY, DP 4246 | | SEX M | AGE(YR./MOS.) 24 / | |
| PT. ADD.: | | | | |
| DATE OF SPECIMEN 11/08/2000 | TIME 9:00 | DATE RECEIVED 11/09/2000 | DATE REPORTED 11/09/2000 | TIME 0:00 2293 |
| TEST | | RESULT | | LIMITS |

RECEIVED
NOV 15 2000
MEDICAL REC.
SCI GRATERFORD

| | |
|---|-------------|
| CLINICAL INFORMATION CD- 52497214728 | |
| PHYSICIAN ID. BEKER | PATIENT ID. |
| ACCOUNT: SCI GRATERFORD PHS ROUTE 29 PO BOX 244 GRATERFORD PA 19426-0000 | |
| ACCOUNT NUMBER: 37101365 | |

CMP12+LP+TP+TSH+6AC+CBC/D/Plt

CHEMISTRIES

| | | | | |
|------------------|-----|-------|-----------|----|
| Glucose, Serum | 89 | mg/dL | 65 - 109 | RN |
| Uric Acid, Serum | 4.5 | mg/dL | 2.4 - 8.2 | RN |

Please Note Reference Interval Change

| | | | | |
|-----------------------------|-----|--------|------------|----|
| BUN | 10 | mg/dL | 5 - 26 | RN |
| Creatinine, Serum | .9 | mg/dL | .5 - 1.5 | RN |
| BUN/Creatinine Ratio | 11 | | | |
| Sodium, Serum | 144 | mEq/L | 135 - 148 | RN |
| Potassium, Serum | 4.4 | mEq/L | 3.5 - 5.5 | RN |
| Chloride, Serum | 105 | mEq/L | 96 - 109 | RN |
| Calcium, Serum | 9.4 | mg/dL | 8.5 - 10.6 | RN |
| Phosphorus, Serum | 3.2 | mg/dL | 2.5 - 4.5 | RN |
| Protein, Total, Serum | 7.9 | g/dL | 6.0 - 8.5 | RN |
| Albumin, Serum | 4.7 | g/dL | 3.5 - 5.5 | RN |
| Globulin, Total | 3.2 | g/dL | 1.5 - 4.5 | |
| A/G Ratio | 1.4 | | 1.1 - 2.5 | |
| Bilirubin, Total | .5 | mg/dL | .1 - 1.2 | RN |
| Alkaline Phosphatase, Serum | 67 | IU/L | 25 - 150 | RN |
| LDH | 124 | IU/L | 100 - 250 | RN |
| AST (SGOT) | 19 | IU/L | 0 - 45 | RN |
| ALT (SGPT) | 24 | IU/L | 0 - 50 | RN |
| GGT | 53 | IU/L | 0 - 85 | RN |
| Iron, Serum | 99 | mcg/dL | | RN |

Diagnostic Reports

Please Note Reference Interval Change

Date / Time: 11/10/00

A N RN NCS

LIPIDS

| | | | | |
|-----------------------|-------|-------------|-----------|----|
| Cholesterol, Total | 134 | mg/dL | 100 - 199 | RN |
| Triglycerides | 55 | mg/dL | 0 - 199 | RN |
| HDL Cholesterol | 41 | mg/dL | 35 - 150 | RN |
| VLDL Cholesterol Calc | 11 | mg/dL | 5 - 40 | |
| LDL Cholesterol Calc | 82 | mg/dL | 0 - 129 | |
| T. Chol/HDL Ratio | 3.2 | Ratio Units | .0 - 5.0 | |
| Estimated CHD Risk | < 0.5 | Times Avg. | .0 - 1.0 | |

(The CHD Risk is based on the
T.Chol/HDL Ratio. Other factors
affect CHD Risk such as hyper-
tension, smoking, diabetes,

T. Chol/HDL Ratio
Men Women

1/2 Avg. Risk 3.4 3.3

Avg. Risk 5.0 4.4

Emre Beken
Medical Dir.

Results are Flagged in Accordance with Age Dependent Reference Ranges

Continued on Next Page

LABORATORY CORPORATION OF AMERICA

| | | | | |
|--------------------------------|--------------|-----------------------------|-----------------------------|--------------|
| SPECIMEN 313-142-3262-0 | TYPE S | PRIMARY LAB RN | REPORT STATUS COMPLETE | Page #: 2 |
| ADDITIONAL INFORMATION | | | | |
| BEKER DOB: 11/04/1976 | | | | |
| PATIENT NAME PEAY, DP 4246 | | SEX M | AGE(YR./MOS.) 24 / | |
| PT. ADD.: | | | | |
| DATE OF SPECIMEN 11/08/2000 | TIME 9:00 | DATE RECEIVED 11/09/2000 | DATE REPORTED 11/09/2000 | TIME 0:00 |
| 2293 | | | | |
| TEST | | RESULT | | LIMITS |
| LAB | | | | |

| | |
|---|-------------|
| CLINICAL INFORMATION CD- 52497214728 | |
| PHYSICIAN ID. BEKER | PATIENT ID. |
| ACCOUNT: SCI GRATERFORD PHS ROUTE 29 PO BOX 244 GRATERFORD PA 19426-0000 ACCOUNT NUMBER: 37101365 | |

severe obesity, and family
history of premature CHD.)

2X Avg.Risk 9.6 7.1
3X Avg.Risk 23.4 11.0

THYROID

TSH, High Sensitivity, Serum

.94

mIU/mL

.35 - 5.50

RN
RN
RN

Male Female

1- 30 days

0.52 - 16.00

0.72 - 13.10

1 mo-5 yrs.

0.55 - 7.10

0.46 - 8.10

>5 yrs.

0.35 - 5.50

0.35 - 5.50

Thyroxine (T4)

7.0

mcg/dL

4.5 - 12.0

RN

T3 Uptake

30

%

24 - 39

RN

Free Thyroxine Index

2.1

1.2 - 4.9

Emre Beken MD
Medical Director

CBC, PLATELET CT, AND DIFF

| | | | | | |
|---|------------------------------|------|------------------------|-------------|----|
| > | White Blood Cell (WBC) Count | 3.4L | X 10 ⁻³ /uL | 4.0 - 10.5 | RN |
| | Red Blood Cell (RBC) Count | 4.91 | X 10 ⁻⁶ /uL | 4.10 - 5.60 | RN |
| | Hemoglobin | 15.2 | g/dL | 12.5 - 17.0 | RN |
| | Hematocrit | 44.7 | % | 36.0 - 50.0 | RN |
| | MCV | 91 | fL | 80 - 98 | RN |
| | MCH | 31.0 | pg | 27.0 - 34.0 | RN |
| | MCHC | 34.1 | g/dL | 32.0 - 36.0 | RN |
| | RDW | 12.5 | % | 11.7 - 15.0 | RN |
| | Platelets | 226 | X 10 ⁻³ /uL | 140 - 415 | RN |
| > | Polys | 31 L | % | 40 - 74 | RN |
| > | Lymphs | 56 H | % | 14 - 46 | RN |
| | Monocytes | 8 | % | 4 - 13 | RN |
| | Eos | 4 | % | 0 - 7 | RN |
| | Basos | 1 | % | 0 - 3 | RN |
| > | Polys (Absolute) | 1.1L | X 10 ⁻³ /uL | 1.8 - 7.8 | RN |
| | Lymphs (Absolute) | 1.9 | X 10 ⁻³ /uL | .7 - 4.5 | RN |
| | Monocytes (Absolute) | .3 | X 10 ⁻³ /uL | .1 - 1.0 | RN |
| | Eos (Absolute Value) | .1 | X 10 ⁻³ /uL | .0 - .4 | RN |
| | Baso (Absolute) | .0 | X 10 ⁻³ /uL | .0 - .2 | RN |

LAB: RN LABCORP RARITAN

69 FIRST AVE, RARITAN, NJ 08869-0000

DIREC

Diagnostic Reports

Name: _____

Date / Time: 11/10/20

Results are Flagged in Accordance with Age Dependent Reference Ranges

Last Page of Report

NCS

19426001 AREA/ROUTE/ST: AO-CH
SCI GRATERFORD
PO BOX 246
GRATERFORD, PA 19426

SB **SmithKline Beecham**
Clinical Laboratories

Perry 094246

| | | | | | | | | | |
|---------------------------------|----------------------------|----------------------------|-----------------------|--|-----------|-------------------------|-----------------------|-------------------------|----------------|
| PATIENT NAME SCIGR2693, 2693 | | PATIENT ID SCIGR2693 | | ROOM NO. | AGE 22 | SEX M | PHYSICIAN KULAYLAT | | |
| PAGE 1 | REQUISITION NO. 0014843 | ACCESSION NO. KP267149P | LAB REF. # 0014843 | COLLECTION DATE & TIME 05041999 10:40 | | LOG-IN-DATE 05051999 | | REPORT DATE 05061999 | & TIME 7:26 |

REMARKS.

EASTE
TIM

| | | | | | | |
|---------------|-------|------|-----------------------|-------|-----------------|----|
| REPORT STATUS | FINAL | TEST | RESULT | UNITS | REFERENCE RANGE | SI |
| | | | IN RANGE OUT OF RANGE | | | CO |

Date of Birth: 11/04/1976

A COPY OF THIS REPORT HAS BEEN SENT TO: CONTRACT LABORATORY SCVS, INC.
1437 DEKALB ST - STE 102
NORRISTOWN, PA 19401

HIV-1 AB SCREEN

NON-REACTIVE

NON-REACTIVE

***NOTE: A NON-REACTIVE RESULT INDICATES THAT HIV1 (HTLV-III)
ANTIBODIES HAVE NOT BEEN FOUND IN THIS PATIENT SPECIMEN.
A NON-REACTIVE RESULT, HOWEVER, DOES NOT PRECLUDE
PREVIOUS EXPOSURE OR INFECTION WITH HIV1.

)) END OF REPORT - SCIGR2693, 2693 KP267149P <<

Diagnostic Reports

Name: Dr. Ramon B. KerenDate: 5/7/99 12:00 PM

A

NCS

A-Requires A DC78 SOAP Note

MAY 11 1999

MEDICAL

19426001 AREA/ROUTE/ST : AD-CH
 SCI GRATERFORD
 PO BOX 246
 GRATERFORD, PA 19426

SB SmithKline Beecham
 Clinical Laboratories

| | | | | | | | | | |
|------------------------------|----------------------------|----------------------------|-----------------------|--|----------|-------------------------|----------|-------------------------|-------------------|
| PATIENT NAME PEAY, DP4246 | | | PATIENT ID DP4246 | | ROOM NO. | AGE 22 | SEX M | PHYSICIAN SOLOMONE | |
| AGE 1 | REQUISITION NO. 0009613 | ACCESSION NO. KP383783M | LAB REF. # 0009613 | COLLECTION DATE & TIME 01141999 06:00 | | LOG-IN-DATE 01151999 | | REPORT DATE 01191999 | & TIME 11:16PM |

REMARKS

EASTER
TIME

| REPORT STATUS | TEST | RESULT | UNITS | REFERENCE RANGE | SITE CODE |
|---------------|------|-------------------------|-------|-----------------|-----------|
| FINAL | | IN RANGE OUT OF RANGE | | | |

Date of Birth: 11/04/1976

A COPY OF THIS REPORT HAS BEEN SENT TO: CONTRACT LABORATORY SCVS, INC.
 1437 DEKALB ST - STE 102
 NORRISTOWN, PA 19401

OVA & PARASITES, FECESES

STATUS: FINAL

CONCENTRATE RESULT: NO PARASITES SEEN

NO WHITE BLOOD CELLS SEEN

TRICHROME RESULT: NO PARASITES SEEN

NO WHITE BLOOD CELLS SEEN

Diagnostic Reports
 Name: _____
 Date: _____
 A-Requires A DC78 SOAP Note

KP

NCS

2/4/99
 Miguel Salomon, M.D.
 CPS Physician

KF

CULTURE, STOOL

(SAL/SHIG/CAMPY)

SOURCE: BOWEL

STATUS: FINAL

RESULT: NO ENTERIC CAMPYLOBACTER, SALMONELLA OR SHIGELLA
 SPECIES ISOLATED.

>> END OF REPORT <<

RECEIVED
 FEB 09 1999
 MEDICAL RECORDS DEPT
 SCI GRATERFORD

Diagnostic Reports
 Name: _____
 Date: _____
 A-Requires a DC 472 SOAP Note

CONTRACT LABORATORY SERVICES, INC.

John J. Zaro, D.O., PhD. - Medical Director
 1437 DeKalb Street, Suite 102, Norristown, Pennsylvania 19401
 Phone: (610) 239-5071 Fax: (610) 239-5079

Name: PEAY ID: DP4246 DOB: 11/04/76 Sex: M

SCI GRATERFORD

Physician: SOLOMON Drawn: 01/11/99

| Test Name | Result | Flag | Units | Range |
|----------------|--------|------|-------|-------------|
| ***** | | | | |
| CBC | | | | |
| WBC | 4.6 | | K/UL | (4.2-10.5) |
| RBC | 4.69 | | M/UL | (4.5-6.30) |
| Hgb | 15.0 | | G/DL | (14-18) |
| HCT | 41.6 | | % | (40-52) |
| MCV | 89 | | FL | (80-97) |
| MCH | 32 | | PG | (27-34) |
| MCHC | 36 | | % | (31.5-36) |
| RDW | 12.4 | | % | (11.5-14.5) |
| PLT | 274.0 | | K/UL | (140-440) |
| POLY % | 35.4 | L | % | (45-70) |
| LYM % | 52.9 | H | % | (22-44) |
| MONO % | 11.7 | | % | (4-12.9) |
| POLY ABSOLUTE | 1.7 | | K/UL | (1.5-7.8) |
| LYMPH ABSOLUTE | 2.4 | | K/UL | (1.5-4.1) |
| MONO ABSOLUTE | 0.5 | | K/UL | (0.2-1.3) |

*** Other ***
 H. Pylori

NEG

+/-

(No Range)

Peter Baddick, D.O.
 Medical Director

RECEIVED

JAN 19 1999

MEDICAL RECORDS DEPT
 SCI GRATERFORD

Diagnostic Reports

Name:

Date:

A

N

NCS

A-Requires a DC 472 SOAP Note

Primary Instrument Operator: L MCGREGOR, MT Signature:
 Date: 01/12/99 Page: 1 Time: 16:32:22

km

JERSEY SHORE HOSPITAL LABORATORY

JERSEY SHORE, PA 17740

05/08/98

PHONE: 717-398-1442

CHEM - 1

5:03

DANIEL HILL, M.D. - DIRECTOR

** FINAL REPORT **

NAME: PEAY STRATTON

MR #: 922542 ID #: 98232891

LOC: SCI-CAMP HILL D ROOM:

SEX: M AGE: 21

DR: LASKEY, MARTIN (CAMPH)

D.O.B. 11/04/76

COPY TO DR. LASKEY, MARTIN (CAMPHILL/DCC)

COLLECTED: 5/07/98 06:35

S2

ACCESSION #: 8127-GL2213

RECEIVED: 5/07/98 17:39

SLJ

COMPLETED: 5/07/98 22:13

PATIENT'S #: DP4246

COMMENT: FAST

REVIEWED BY

NOT SIGNIFICANT UNLESS

PHIL RICHARDSON, PA-C
PHYSICIAN ASSISTANT - WHS
12 MAY 1998

| PROCEDURE | RESULT | UNITS | EXPECTED RANGE | TECH |
|-------------------|------------|-------------------|----------------|------|
| CHEMISTRY | | | | |
| PROFILE | | | | |
| HEALTH PROFILE #3 | | | | |
| WBC | 3.5 L | X 10 ³ | 4.5-11.0 | SE |
| RBC | 4.93 | X 10 ⁶ | 4.20-5.40 | SE |
| HGB | 15.1 | g/dl | 13.0-17.0 | SE |
| HCT | 44.4 | % | 38.0-52.0 | SE |
| MCV | 90.2 | um ³ | 80.0-100.0 | SE |
| MCH | 30.7 | pg | 26.0-33.0 | SE |
| MCHC | 34.0 | g/dl | 32.0-36.0 | SE |
| RDW | 12.3 | % | 11.0-15.0 | SE |
| PLT | 216 | X 10 ³ | 150-450 | SE |
| MPV | 9.3 | um ³ | 7.4-10.4 | SE |
| LYMPH % | 52.1 H (1) | % | 20.0-45.0 | SE |
| MONO % | 10.7 | % | 1.0-12.0 | SE |
| NEUT% | 33.1 L | % | 55.0-75.0 | SE |
| EOS% | 3.8 | % | 0.0-4.0 | SE |
| BASO% | 0.3 | % | 0.0-1.0 | SE |
| LYMPH # | 1.8 | X 10 ³ | 1.0-4.5 | SE |
| MONO # | 0.4 | X 10 ³ | 0.0-0.8 | SE |
| NEUT# | 1.2 L | X 10 ³ | 2.0-7.7 | SE |
| EOS | 0.1 | X 10 ³ | 0.0-0.7 | SE |
| BASO | 0.0 | X 10 ³ | 0.0-0.2 | SE |
| GLUCOSE | 79 | mg/dl | 70-105 | MB |
| SODIUM | 137 | mEq/L | 133-145 | MB |
| POTASSIUM | 3.9 | mEq/L | 3.3-5.1 | MB |
| CHLORIDE | 103 | mEq/L | 96-108 | MB |
| CARBON DIOXIDE | 26 | mmol/L | 22-29 | MB |
| CALCIUM | 8.8 | mg/dl | 8.4-10.2 | MB |
| PHOSPHORUS | 3.4 | mg/dl | 2.6-4.5 | MB |
| LDH | 131 | U/L | 94-250 | MB |
| SGOT/AST | 19 | U/L | 0-37 | MB |
| SGPT/ALT | 25 | U/L | 0-40 | MB |
| ALK PHOS | 75 | U/L | 39-117 | MB |
| GGT | 48 | U/L | 11-51 | MB |

(1) LYMPHOCYTOSIS

JERSEY SHORE HOSPITAL LABORATORY
1020 THOMPSON ST.

05/08/98
5:03

JERSEY SHORE, PA 17740-0689
DANIEL HILL, M.D. - DIRECTOR
** FINAL REPORT **

CHEM - 2

NAME: PEAY STRATTON
LOC: SCI-CAMP HILL D ROOM:
DR: LASKEY, MARTIN (CAMPH
COPY TO DR. LASKEY, MARTIN (CAMPHILL/DCC)

MR #: 922542 ID#: 98232891
SEX: M AGE: 21
D.O.B. 11/04/76

COLLECTED: 5/07/98 06:35 S2
RECEIVED: 5/07/98 17:39 SLJ
COMPLETED: 5/07/98 22:13

ACCESSION #: 8127-GL2213

PATIENT'S #: DP4246

REVIEWED BY

PHIL RICHARDSON, PA-C
PHYSICIAN ASSISTANT - WH
12 MAY 1998

COMMENT: FAST

NOT SIGNIFICANT UNLESS

| PROCEDURE | RESULT | UNITS | EXPECTED RANGE | TECH |
|-----------------------------|----------|-------|----------------|------|
| HEALTH PROFILE #3 Continued | | | | |
| TOTAL BILIRUBIN | 0.6 | mg/dl | 0.0-1.0 | MB |
| DIRECT BILIRUBIN | 0.1 | mg/dl | 0.0-0.3 | MB |
| BUN | 10 | mg/dl | 6-19 | MB |
| CREATININE | 0.7 | mg/dl | 0.5-1.2 | MB |
| URIC ACID | 5.2 | mg/dl | 3.4-7.0 | MB |
| TOTAL PROTEIN | 7.6 | G/DL | 5.9-8.4 | MB |
| ALBUMIN | 4.8 | g/dl | 3.2-5.2 | MB |
| CHOLESTEROL | 129 | mg/dl | 0-200 | MB |
| TRIGLYCERIDE | 75 | mg/dl | 25-200 | MB |
| GLOBULIN | 2.8 | g/dl | 2.3-5.3 | MB |
| A/G RATIO | 1.71 | | 1.06-1.95 | MB |
| RPR | NONREACT | | | MB |
| COLOR | YELLOW | | | SH |
| APPEARANCE | CLEAR | | | SH |
| GLUCOSE | NEGATIVE | | | SH |
| BILIRUBIN | NEGATIVE | | | SH |
| KETONE | NEGATIVE | | | SH |
| SP. GR. | 1.020 | | | SH |
| pH | 6.5 | | 4.5-8.0 | SH |
| PROTEIN | NEGATIVE | | | SH |
| UROBILINOGEN | 0.2 | EU/dl | 0.1-2.0 | SH |
| NITRITE | NEGATIVE | | | SH |
| BLOOD | NEGATIVE | | | SH |
| LEUK. ESTERASE | TRACE A | | | SH |

UPK

JERSEY SHORE HOSPITAL LABORATORY
1020 THOMPSON ST.05/08/98
5:03JERSEY SHORE, PA 17740-0689
DANIEL HILL, M.D. - DIRECTOR
** FINAL REPORT **

URINE - 1

NAME: PEAY STRATTON
LOC: SCI-CAMP HILL D ROOM:
DR: LASKEY, MARTIN (CAMPH
COPY TO DR. LASKEY, MARTIN (CAMPHILL/DCC)MR #: 922542 ID#: 98232891
SEX: M AGE: 21
D.O.B. 11/04/76COLLECTED: 5/07/98 06:35 S2
RECEIVED: 5/07/98 17:39 SLJ
COMPLETED: 5/07/98 22:13ACCESSION #: 8127-GL2213 PA-C
PATIENT'S #: DP4246
PHIL RICHARDSON, PA-C
PHYSICIAN ASSISTANT - WHS
12 MAY 1998

COMMENT: FAST

REVIEWED BY
NOT SIGNIFICANT UNLESS

=====

PROCEDURE RESULT UNITS EXPECTED RANGE TECH

=====

URINALYSIS

URINALYSIS

U/A + MICROSCOPIC

| | | | | |
|------------------|-----------|------|--|----|
| URINE WBC'S | 5-10 A | /hpf | | SH |
| URINE RBC'S | 2-4 A | /hpf | | SH |
| URINE BACTERIA | NONE SEEN | /hpf | | SH |
| EPITHELIAL CELLS | NONE SEEN | /hpf | | SH |
| URINE MUCUS | NONE SEEN | /lpf | | SH |
| URINE CASTS | NONE SEEN | /lpf | | SH |
| URINE CRYSTALS | NONE SEEN | /lpf | | SH |

PRA

Correcuonal Industries Optical Laboratory

451 Fullerton Avenue - Cambridge Springs, Pennsylvania 16403

(814) 398-5400 EXT. 5616 FAX (814) 398-5617

| | | | |
|--|--------------|---------------------------|---------------------------------------|
| PATIENT <u>Peay</u> | | CONTACT PERSON <u>Val</u> | |
| INSTITUTION <u>SLIC</u> | | DOC # <u>DP 4246</u> | |
| DIST. | SPHERE | CYL. | AXIS |
| R | <u>+0.05</u> | | |
| L | | | |
| NEAR | ADD | SEG. HGT. | SEG. TYPE |
| R | | | |
| L | | | |
| DECENTER | | PRISM & BASE | |
| IN | | OUT | |
| R | | L | |
| NEAR | | P.D. | |
| R | | L | |
| NEAR | | L | |
| CIRCLE ONE: <u>LAB SUPPLY</u> FRAME ENCL. TO COME LENSES ONLY CALL FOR FRAME | | | |
| PLASTIC FRAME METAL RIMLESS HALF-EYE | | | |
| FRAME MFG - STYLE | | NAME | |
| <u>M150</u> | | | |
| EYE SIZE | BRIDGE | COLOR | LEN'S INFORMATION |
| <u>49</u> | | <u>Brown</u> | CIRCLE ONE TINT COATING |
| TEMPLE SIZE AND STYLE | DROP BALL | DATE | 2.2 THK PLASTIC HI INDEX PLASTIC |
| <u>140</u> | | <u>3-22-9</u> | 3.0 IND. THK POLYCARB OTHER - SPECIFY |
| | | LENS COLOR _____ | |

VISION SAFETY NOTICE: READ & SIGN BELOW

* Your lenses meet or exceed American National Standard Z80.1 and FDA requirement 21 CFR Sec 801.410 for impact resistance but are not unbreakable or shatterproof. Of all the materials that lenses can be made from polycarbonate is the most impact resistant.

* If struck with sufficient force, the lenses can break into sharp pieces that can cause serious injury to the eye, or blindness. Even if the lenses do not break, the force of impact may cause the lenses or spectacle frame to contact the eye or surrounding area causing injury.

* The continued impact resistance of your lenses depends on how well you protect them from physical shocks and abuse. For your protection, scratched or pitted lenses should be replaced immediately.

* If your occupational and recreational activities expose you to the risk of flying objects or physical impacts, your eye safety requires special safety spectacles with safety lenses, side shields, goggles and/or a full face shield.

SPECIAL INSTRUCTIONS:

INMATE'S SIGNATURE: PeayR No. 269

FACTORY ORDER #

243381

DATE ORDERED

DATE RECEIVED

DATE COMPLETED

DISTRIBUTION: WHITE - INVOICE CANARY - CUSTOMER PINK - LAB OFFICE GOLDENROD - SENDING INSTITUTION

| | PHS CHARGE | INMATE CHARGE |
|--------------|--------------|---------------|
| FRAME CHARGE | <u>3.00</u> | |
| LENS CHARGE | <u>8.50</u> | |
| COLOR | | |
| PRISM | | |
| - DIOPTR | | |
| ± 6SPH 2CYL. | | |
| EDGE | | |
| RIMLESS | | |
| CASE | | |
| SHIPPING | <u>1.75</u> | |
| | | |
| | | |
| TOTAL | <u>12.25</u> | |
| BILLING DATE | | |

Date 3/22/01 Time _____ History _____

None

| V.A. | Unaided (Distance) | Unaided (Near) | With Old R (Distance) | Old R (Near) |
|------|--------------------|---------------------------|-----------------------|--------------|
| O.D. | <u>20/2</u> | O.D. <u>J₁</u> | O.D. _____ | O.D. _____ |
| O.S. | <u>20/2</u> | O.S. <u>J₁</u> | O.S. _____ | O.S. _____ |

External Examination None

Ophthalmoscopy None

Tonometry _____ OD _____ OS _____

Remarks Re-Exam 3/22

Phoria _____ Hor. _____ Ver. _____ Near _____

R: O.D. +0.75 V.A. _____ O.S. +0.75 V _____

P.D. _____ Signature [Signature] William Troppanuer M.D./O
Optometry

DC-451

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF CORRECTIONS
OPHTHALMOLOGIC/OPTOMETRIC
EXAMINATION RECORD

Inmate Name: Peay

Inmate Number: DP 4246

DOB: _____

Institution: _____

TELEBINOCULAR/AUDIOGRAM TESTING

Date: 5/8/08Pass /Fail mmDepth Perception Color Perception

(Any failure of depth or color perception should be reflected in the PULHEST rating.)

ACUITY TESTAcuity ValuesBoth EyesRight EyeLeft Eye

Far Point

20/2020/2020/30

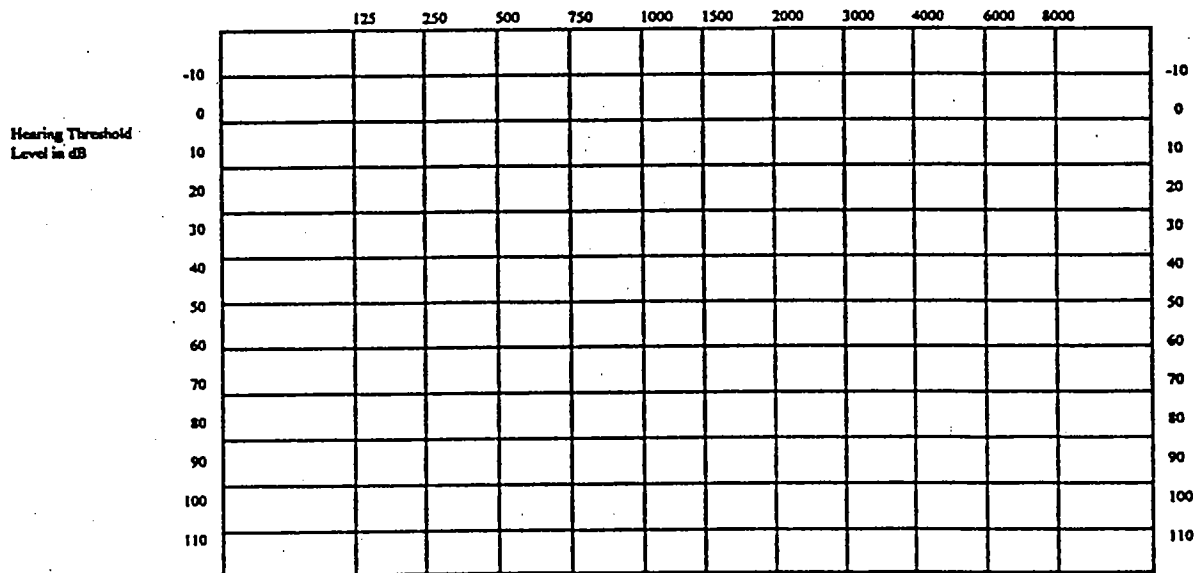
Near Point

20/2020/2020/30TESTEDWith Glasses/Contacts Without Glasses/Contacts

(If acuity value of either or both eyes is above 20/40 then the inmate should be referred to optometrist)

Date:

AUDIOGRAM



| | | | | | | | | | | | | |
|-----|-------|-----|-----|-----|-----|------|------|------|------|------|------|------|
| | | 125 | 250 | 500 | 750 | 1000 | 1500 | 2000 | 3000 | 4000 | 6000 | 8000 |
| EAR | RIGHT | | | 20 | | 10 | | 10 | 5 | 10 | | |
| | LEFT | | | 20 | | 10 | | 10 | 5 | 15 | | |

Telebinocular/Audiogram Testing
Commonwealth of Pennsylvania
Department of Corrections
DC -

Inmate Name:

Pey, Stratton

Inmate Number:

DP 4246

DOB:

11/4/76

Institution:

SCIC

| MO./DAY/YR. | | A.M. | | P.M. | | A.M. | | P.M. | | A.M. | | P.M. | | A.M. | | P.M. | |
|----------------|-----|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|
| HOUR | | | | | | | | | | | | | | | | | |
| Pulse (Circle) | 150 | | | | | | | | | | | | | | | | |
| | 140 | | | | | | | | | | | | | | | | |
| | 130 | 106 | | | | | | | | | | | | | | | |
| | 120 | 105 | | | | | | | | | | | | | | | |
| | 110 | 104 | | | | | | | | | | | | | | | |
| | 100 | 103 | | | | | | | | | | | | | | | |
| | 90 | 102 | | | | | | | | | | | | | | | |
| | 80 | 101 | | | | | | | | | | | | | | | |
| | 70 | 100 | | | | | | | | | | | | | | | |
| | 60 | 99 | | | | | | | | | | | | | | | |
| 50 | 98 | | | | | | | | | | | | | | | | |
| 40 | 97 | | | | | | | | | | | | | | | | |
| 30 | 96 | | | | | | | | | | | | | | | | |
| Respirations | | | | | | | | | | | | | | | | | |
| Blood Pressure | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | |
| Weight | | | | | | | | | | | | | | | | | |
| Intake | | | | | | | | | | | | | | | | | |
| Output | | | | | | | | | | | | | | | | | |
| Initials | | AM | | | | | | | | | | | | | | | |
| | | PM | | | | | | | | | | | | | | | |

Inpatient Vital Signs Flow Sheet
Commonwealth of Pennsylvania
Department of Corrections
DC-475

Inmate Name: *PEAY*

Inmate Number: *DP 4246*

DOB:

Institution: *SCI GRA*

JUL 17 2002

MEDICAL RECORDS DE-
SCI GRATERFORD

INDIVIDUAL TREATMENT PLAN

| | | | | | | |
|--|--|---|----------|---|--|----------|
| (1) Name S. Peay | | (2) OC# DP-4246 | | (3) Assigned PSA R. L. Adrine | | |
| (4) ICD Code None | | (5) GAF 75 | | (6) Assigned Psychiatrist Dr. Hemmighan | | |
| (7) Date of Last Treatment Plan Review | | | | | | |
| (8) Problems & Goals (Minimum of 2) | | (9) Treatment Objectives (Observable & Measurable) | | (10) Objectives Target Date | | |
| <p>No indications from intake or any psychiatric/psychological problem. Mr. Peay again called on 6/25/82 and stated he was suicidal in order to get to infirmary to discuss medical problem.</p> | | <p>Cleared for discharge by Psychiatry</p> | | <p>None</p> | | |
| Treatment Modalities Check All That Apply | | Projected Frequency & Duration of Treatment | | | (11) Anticipated Length of Treatment Up to 3 Mos. _____ Up to 6 Mos. _____ More than 1 Year _____ | |
| | | Once/wk | Twice/wk | Every 2 Weeks | | Once/Mo. |
| (12) Individual | | | | | | |
| (13) Group | | | | | | |
| | | | | | | |
| (14) Employment | | | | | | |
| (15) Education | | | | | | |
| (16) Other (Specify) | | | | | | |

Review/Updates

Review and Update Treatment Plan on a new form as follows:

1. Initial Review (to be completed within 14 days of admission).
2. SNU reviews a minimum of one every 120 days.
3. At the request of the Unit Manager.

(17) Client Signature/Date

(19) Counselor Signature

Date _____

(18) Psychology Staff/Date
Signature

(20) Psychiatrist Signature/Date

(21) Unit Manager Signature/Date

Admission - 1000

INPATIENT UNIT NURSING CARE PLAN

Admission Date 6/24/02 Discharge Date _____Diagnosis SH

Please remember that each entry must be signed.

| DATE | PROBLEM OR NURSING DIAGNOSIS | NURSING INTERVENTION | OBJECTIVE AND/OR EXPECTED OUTCOME | DATE RESOLVED/CHANGED |
|---------|------------------------------|---|---|-----------------------|
| 6/24/02 | At risk for self harm. | 1:1 4 vest 4 blanket F. Food 4 Meads 4 eval Med. eval | Stabilize Caudex Disch to blk F/u 4 | |

JAN
MEDICAL RECORDS DEPT
SCI GRATERFORD

RELEASE FROM RESPONSIBILITY FOR MEDICAL TREATMENT

I, PEAY, an inmate at S.C.I. GRATERFORD
(Inmate's name) (Institution)
 have been advised by the physician named below that I am in need of medical treatment for:

X-RAY (KUB)

I understand the nature of the treatment is: (Attending physician: Give brief description of the medical treatment required, and the possible consequences of this inmate not receiving it.)

I hereby refuse this treatment. I have been fully advised of the nature of my ailment or injury and fully realize the effects that may result from my refusal to accept the prescribed treatment. I hereby release the attending physician, and the institution from all legal responsibility for any ill effects which may result from my refusal to accept medical treatment.

In signing this I certify that the above has been read and fully explained to me.

REFUSED 12.31.01
 Inmate Signature Date

SAMUEL KOTCH M.D. 12/31/01
 Physician Signature Date

Col. [Signature] 12.31.01
 Witness Signature Date

[Signature] 12/31/01
 Witness Signature Date

Release from Responsibility for
 Medical Treatment
 Commonwealth of Pennsylvania
 Department of Corrections
 DC-462

Inmate Name PEAY
 Inmate Number DP4246
 DOB:
 Institution: SCIG

RECEIVED
 JAN 02 2001
 MEDICAL RECORDS DEPT
 SCI GRATERFORD

RE: HIV CONSENT FORM
 PENNA. DEPT. OF CORRECTIONS
SCI/GRATERFORD
 Page 2 of 2

COMMENT

I have read or someone has read to me the information on this form. I have received an explanation about this information. I have also been given or offered information about ways to prevent infecting myself and others with the HIV virus. I have had a chance to ask questions and those questions have been answered to my satisfaction. I request that a sample of blood be taken from me and tested for HIV antibodies. I have been told how I will receive my test results and I agree to receive my results that way.

The fact that I have been tested and my results, together with any information that identifies or can be used to identify me, are confidential and, except as otherwise permitted by law, will not be given to anyone without my signed permission.

INFORMATION ON PERSON REQUESTING AN HIV ANTIBODY TEST (PRINT)

Perry Stoltan 11-4-76 22
 Last Name First Name MI Birthdate Age

SCI/Graterford
 Institution

DP4246
 Inmate Number

Graterford **RECEIVED** Montgomery PA 19401
 City JUN 02 1999 County State Zip

MEDICAL RECORDS DEPT
 SCI GRATERFORD

XQ. Ray
 Signature of Person Consenting to the Test

5-4-99
 Date

M. Becherera

I hereby authorize the performance upon STRATTUN PEAY
Name of Patient

of the following procedure REMOVAL OF WARTS ON LEFT THIGH
Name or description of operation or other procedure to be performed

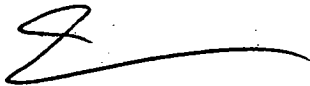
To be performed under the direction of Dr. NEEL C HEFFERNAN PA-C

I acknowledge that the nature of such operation or procedure, its seriousness and probable outcome have been explained to me. I also acknowledge that no guarantee has been given to me by anyone concerning the results which may be obtained.

I understand that in consenting to the performance of this operation or procedure, I am authorizing as well all procedures which are ordinarily incident to the procedure including the administration of such anesthetics as may be considered advisable.

I consent to the disposal by medical department authorities of any tissues or parts which may be removed.

I consent to the performance of operations and procedures in addition to or different from those contemplated which the above named doctor or his associates or assistants may consider necessary or advisable in the course of the operation.



Witness

NEIL HEFFERNAN, PA-C
PHYSICIAN ASSISTANT - WHS

G. PEAY DP 4246

Patient or person authorized to consent for patient

Relationship to Patient of person signing if other than Patient

Institution SCI CAMP HILL

Date 7-21-98

DC-77

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF CORRECTIONS
CONSENT TO OPERATION OR
OTHER MEDICAL PROCEDURES

Inmate Identification

D.O.B. 11-4-76

SSN

Inst. No. DP-4246

Name PEAY, STRATTUN

SELF-MEDICATION DISTRIBUTION PROGRAM INSTRUCTIONS

You have been selected to participate in a self-medication distribution program. You will receive up to a one month's supply of some of your medication.

You may need to report to the medication line daily for certain medications which are not allowed to be kept in your possession.

You must assume responsibility to take your medications properly, as labeled. Any medication found outside of the package, any selling of medication, any reported stolen medication or any loss of the medication package may result in your being removed from the self-medication distribution program. Any misuse of the medication could result in a misconduct. You must show all medication in your possession to any staff member upon request.

To obtain refills of your medication you must:

1. Report to (A.M.) morning medication line.
2. Bring your Photo I.D. - Be prepared to show your I.D. to Nursing Staff.
3. Bring your empty medication card, bottle, tube, inhaler, etc., in order to receive refill.

I have received both written and verbal instructions on the self-medication distribution program, and I understand these instructions.

Y.B. Pay
Inmate Signature

5-6-98
Date

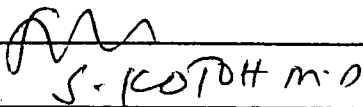
[Signature] 5/6/98
Nurse Signature Date

White - Medical Record - File Under Legal

Canary - Inmate's Copy

Self-Medication Distribution
Program Instructions
Commonwealth of Pennsylvania
Department of Corrections DC-499

Inmate Name: Pay, Stratton
Inmate Number: DP4246
DOB: 11/4/76

| DEPARTMENT OF CORRECTIONS | | THERAPEUTIC DIET ORDER FORM | | MEDICAL NUTRITION THERAPY |
|---|---------------------------------|--|--------------------|---------------------------|
| Order Date: <u>2/21/02</u> | Expiration Date: <u>8/21/02</u> | Height: <u>5' 8"</u> | Weight: <u>177</u> | |
| Potential food/drug interaction problems? (i.e., Lithium, MAO Inhibitors, Theophylline): Yes _____ No _____ (If Yes, explain): | | | | |
| PA DOC STANDARD DIETS | | | | |
| <input type="checkbox"/> DIABETIC: Circle calorie level. Diabetic diets have a total fat content <30%, Na restricted; HS snack <u>automatically</u> included. <div style="display: flex; justify-content: space-around; width: 100%;"> 1500 2000 2500 3000 </div> | | <input type="checkbox"/> CARDIAC: Fat/Cholesterol/Sodium Restricted: Total fat <30% of total calories; Saturated fat <7% of total calories; Cholesterol <200 mg/day; Sodium 3000-4000 mg; approximately 2500Kcal. | | |
| <input type="checkbox"/> HIGH KCAL/PRO: 120 gram protein, >4000 kcal. | | <input type="checkbox"/> MECHANICAL SOFT: Consistency modified to minimize need for chewing | | |
| <input type="checkbox"/> RENAL (NON-DIALYSIS): 60 gram protein, sodium, potassium, phosphorus & fluid controlled | | <input type="checkbox"/> CLEAR LIQUID: (duration 3 days max) | | |
| <input type="checkbox"/> RENAL (DIALYSIS): 80 gram protein, sodium, potassium, phosphorus & fluid controlled | | <input type="checkbox"/> FULL LIQUID: (duration 3 days max) | | |
| <input type="checkbox"/> OTHER NON-STANDARD DIET: | | | | |
| Additional modifications/comments: <div style="font-size: 2em; text-align: center;">H H Diet</div> | | | | |
| Physician/PA Signature:  | | | | |

WHITE — Medical Records

CANARY — Food Service

Therapeutic Diet Order
Commonwealth of Pennsylvania
Department of Corrections
DC-465

Inmate Name: PEAY

Inmate Number: DP 4246

DOB:

Institution: SCI CRA

(LBIOL)

3 2/21/02

INTER-INSTITUTIONAL TRANSFER RECEPTION SCREENING

Transferring Institution: Camp Hill Receiving Institution: Mra Date: 8-21-96

Current Acute Conditions/Problems: X

Chronic Conditions/Problems: X

Medications: (Name, Dosage, Frequency, Duration) X

Allergies: NKDA

Dietary Restrictions: X

Physical Disabilities/Limitations: X

Visible Signs of Dental Problems: X

Bruises, Deformities, Evidence of Trauma: X

Significant Medical History: hx GSW 1996: ABD / R leg

History of Drug/Alcohol Abuse (Specify): denies

General Appearance and Behavior: calm, lucid, cooperative

Complaints: no c/o

PHYSICAL AIDS

| (check as appropriate) | YES | NO | DESCRIPTION | | YES | NO | DESCRIPTION |
|------------------------|-----|----|-------------|-------------------|-----|----|-------------|
| Eye glasses | | / | | Orthotics, Braces | | / | |
| Contact Lens | | / | | Artificial Limbs | | / | |
| Eye Prosthesis | | / | | Crutches/Cane | | / | |
| Hearing Aid | | / | | Wheelchair | | / | |
| Dentures | | / | | Other | | / | |

FEMALES ONLY

Gravida Para

Date of Last Menstrual Period MA

Any chance of pregnancy now? Yes No

Any gynecological problems?

**Inter-Institutional Transfer Reception
Screening**

**Commonwealth of Pennsylvania
Department of Corrections**

DC-479

Inmate Name: Peay

Inmate Number: DP 4246

DOB: 11-4-76

Institution: Mra

INTER-INSTITUTIONAL TRANSFER RECEPTION SCREENING

Transferring Institution Sci-Crest Receiving Institution: Sci-Camp Hill Date: 5/6/98

Current Acute Conditions/Problems: n/a (2) knee buckling under he

Chronic Conditions/Problems: none

Medications: (Name, Dosage, Frequency, Duration) none

Allergies: none NKDA

Dietary Restrictions: none

Physical Disabilities/Limitations: none

Visible signs of Dental Problems: none

Bruises, Deformities, Evidence of Trauma: none

Significant Medical History: CSW 1994 to Abd + Leg

History of Drug/Alcohol Abuse (Specify): marijuana, alcohol

General Appearance and Behavior: WNL

Complaints: _____

PHYSICAL AIDS

| (check as appropriate) | YES | NO | DESCRIPTION | | YES | NO | DESCRIPTION |
|------------------------|-----|-------------------------------------|-------------|-------------------|-----|-------------------------------------|-------------|
| Eyeglasses | | <input checked="" type="checkbox"/> | | Orthotics, Braces | | <input checked="" type="checkbox"/> | |
| Contact Lens | | <input checked="" type="checkbox"/> | | Artificial Limbs | | <input checked="" type="checkbox"/> | |
| Eye Prosthesis | | <input checked="" type="checkbox"/> | | Crutches/Cane | | <input checked="" type="checkbox"/> | |
| Hearing Aid | | <input checked="" type="checkbox"/> | | Wheelchair | | <input checked="" type="checkbox"/> | |
| Dentures | | <input checked="" type="checkbox"/> | | Other | | | |

FEMALES ONLY

Gravida _____ Para _____

Date of Last Menstrual Period _____

Any chance of pregnancy now? Yes No

Any gynecological problems? _____

Inter-Institutional Transfer Reception
Screening
Commonwealth of Pennsylvania
Department of Corrections
DC-479

Inmate Name: Play, Stratton

Inmate Number: DP46246

DOB: 11/4/76

Institution: Sci-Camp Hill

MENTAL HEALTH STATUS

| (Check as Appropriate) | Yes | No | Comments |
|--|-----|-------------------------------------|----------|
| Do you hear voices? | | <input checked="" type="checkbox"/> | |
| Do you have thoughts hurting yourself or others? | | <input checked="" type="checkbox"/> | |
| Do you have history of depression? | | <input checked="" type="checkbox"/> | |
| Is there a history of suicide attempts? | | <input checked="" type="checkbox"/> | |
| Is there evidence of self-mutilation? | | <input checked="" type="checkbox"/> | |

Psychiatric Follow-up care is needed (Circle those that apply):

Yes

☒ No

Immediate

Routine

Medical Follow-up care is needed (Circle those that apply):

Yes

☒ No

Immediate

Routine

Procedures for obtaining medical services explained (Circle one):

☒ Yes

No

Nurse Signature, Title

Date/Time

Inmate Signature

Date

Witness Signature (if inmate refuses to sign)

Date

Medical Chart Reviewed (Circle one): Yes No

Psychiatric referral is needed (Circle those that apply):

Yes

No

Emergency

Routine

Medical referral is needed (Circle those that apply):

Yes

No

Emergency

Routine

Is inmate medically cleared for general population?

Yes

No

Reviewing Nurse Signature, Title

Date/Time

INTER-INSTITUTIONAL TRANSFER RECEPTION SCREENING

Transferring Institution SCI-Cit Receiving Institution: SCI-Camp Hill Date: 5/6/98

Current Acute Conditions/Problems: 1/10 (2) knee buckling under h

Chronic Conditions/Problems: none

Medications: (Name, Dosage, Frequency, Duration) none

Allergies: none NKDA

Dietary Restrictions: none

Physical Disabilities/Limitations: none

Visible signs of Dental Problems: none

Bruises, Deformities, Evidence of Trauma: none

Significant Medical History: CSW 1994 to Abd + legs

History of Drug/Alcohol Abuse (Specify): marijuana, alcohol

General Appearance and Behavior: WNL

Complaints: _____

PHYSICAL AIDS

| (check as appropriate) | YES | NO | DESCRIPTION | YES | NO | DESCRIPTION |
|------------------------|-----|-------------------------------------|-------------|-----|-------------------------------------|-------------------|
| Eyeglasses | | <input checked="" type="checkbox"/> | | | <input checked="" type="checkbox"/> | Orthotics, Braces |
| Contact Lens | | <input checked="" type="checkbox"/> | | | <input checked="" type="checkbox"/> | Artificial Limbs |
| Eye Prosthesis | | <input checked="" type="checkbox"/> | | | <input checked="" type="checkbox"/> | Crutches/Cane |
| Hearing Aid | | <input checked="" type="checkbox"/> | | | <input checked="" type="checkbox"/> | Wheelchair |
| Dentures | | <input checked="" type="checkbox"/> | | | <input checked="" type="checkbox"/> | Other |

FEMALES ONLY

Gravida _____ Para _____

Date of Last Menstrual Period _____

Any chance of pregnancy now? Yes No

Any gynecological problems? _____

Inter-Institutional Transfer Reception
Screening
Commonwealth of Pennsylvania
Department of Corrections
DC-479

Inmate Name: Play Stratton

Inmate Number: DP4246

DOB: 11/4/76

Institution: SCI Camp Hill

MENTAL HEALTH STATUS

| (Check as Appropriate) | Yes | No | Comments |
|--|-----|-------------------------------------|----------|
| Do you hear voices? | | <input checked="" type="checkbox"/> | |
| Do you have thoughts hurting yourself or others? | | <input checked="" type="checkbox"/> | |
| Do you have history of depression? | | <input checked="" type="checkbox"/> | |
| Is there a history of suicide attempts? | | <input checked="" type="checkbox"/> | |
| Is there evidence of self-mutilation? | | <input checked="" type="checkbox"/> | |

Psychiatric Follow-up care is needed (Circle those that apply):

Yes

☒ No

Immediate

Routine

Medical Follow-up care is needed (Circle those that apply):

Yes

☒ No

Immediate

Routine

Procedures for obtaining medical services explained (Circle one):

☒ Yes

No

Nurse Signature, Title

Date/Time

Inmate Signature

Date

Witness Signature (if inmate refuses to sign)

Date

Medical Chart Reviewed (Circle one): Yes No

Psychiatric referral is needed (Circle those that apply):

Yes

No

Emergency

Routine

Medical referral is needed (Circle those that apply):

Yes

No

Emergency

Routine

Is inmate medically cleared for general population?

Yes

No

Reviewing Nurse Signature, Title

Date/Time

OBSERVATIONS

| | NORMAL or NONE | ABNORMAL/COMMENTS: |
|-----------------------------|-------------------------------------|--------------------|
| Appearance | <input checked="" type="checkbox"/> | |
| Tremors | <input checked="" type="checkbox"/> | |
| Sweating | <input checked="" type="checkbox"/> | |
| Any Recent Injury (specify) | <input checked="" type="checkbox"/> | |
| Bruises | <input checked="" type="checkbox"/> | |
| Lesions | <input checked="" type="checkbox"/> | |
| Jaundice | <input checked="" type="checkbox"/> | |
| Rashes | <input checked="" type="checkbox"/> | |
| Infestation | <input checked="" type="checkbox"/> | |
| Needle marks | <input checked="" type="checkbox"/> | |
| Persistent Cough | <input checked="" type="checkbox"/> | |
| Lethargy | <input checked="" type="checkbox"/> | |
| Speech & Posture | <input checked="" type="checkbox"/> | |
| Teeth and Gums | <input checked="" type="checkbox"/> | |
| Physical Limitations | <input checked="" type="checkbox"/> | |
| Deformities | <input checked="" type="checkbox"/> | |
| Ease of Movement | <input checked="" type="checkbox"/> | |
| Other | | |

PHYSICAL AIDS

| (check as appropriate) | YES | NO | DESCRIPTION | YES | NO | DESCRIPTION |
|------------------------|-----|-------------------------------------|-------------|-----|-------------------------------------|-------------------|
| Eyeglasses | | <input checked="" type="checkbox"/> | | | <input checked="" type="checkbox"/> | Orthotics, Braces |
| Contact Lens | | <input checked="" type="checkbox"/> | | | <input checked="" type="checkbox"/> | Artificial Limbs |
| Eye Prosthesis | | <input checked="" type="checkbox"/> | | | <input checked="" type="checkbox"/> | Crutches/Cane |
| Hearing Aid | | <input checked="" type="checkbox"/> | | | <input checked="" type="checkbox"/> | Wheelchair |
| Dentures | | <input checked="" type="checkbox"/> | | | <input checked="" type="checkbox"/> | Other |

List physical aids sent with inmate: Ø**FEMALES ONLY:**Menstrual Period (circle one): Regular Irregular
Para/Gravida _____Last Menstrual Period: _____
Last Pap Smear _____

Any chance of pregnancy now? (circle one): YES NO

Any Gynecological Problems? _____

Initial Reception Screening
Commonwealth of Pennsylvania
Department of Corrections
DC-471

Inmate Name:

PEAY, STRATTON

Inmate Number:

DP-4246

DOB:

DOB: 11/04/76

Institution:

MENTAL HEALTH REVIEW:

| (check as appropriate) | YES | NO |
|---|-------------------------------------|-------------------------------------|
| Do you hear voices? | | <input checked="" type="checkbox"/> |
| Do you have thoughts of hurting yourself or others? | | <input checked="" type="checkbox"/> |
| Do you have a history of depression? | | <input checked="" type="checkbox"/> |
| Impaired Speech? | | <input checked="" type="checkbox"/> |
| Evidence of self-mutilation? | | <input checked="" type="checkbox"/> |
| Oriented to time, place, person? | <input checked="" type="checkbox"/> | |
| Other significant observations? | | <input checked="" type="checkbox"/> |

Observations: _____

Suicide attempts: (circle one)

Yes

No

If yes, How many times? _____

If yes, why/where/when/how: _____

Past Psychiatric Hospitalizations/Outpatient Treatments/Partial Hospitalizations: _____

Previous Diagnosis as stated by Inmate: _____

Psychotropic Medications, Dosage and Frequency: _____

When last taken: _____

Psychiatric referral is needed (Circle those that apply):

Yes

No

Emergency

Routine

Medical referral is needed (Circle those that apply):

Yes

No

Emergency

Routine

If yes, indicate date and time referral was made:

Date

Time

Is inmate medically cleared for general population?

Yes

No

Access to medical service explained to inmate?

Yes

No

Interviewer's Signature, Title

Date/Time

Inmate Signature

Date

Witness (if inmate refuses to sign)

Date

Interpreter Signature (if needed)

Date

INMATE IMMUNIZATION RECORD

Allergies: Ø

| | | | | | | |
|------------------------------------|-----------|---------|--|--|--|--|
| IMMUNIZATION Tetanus/Diphtheria | Date: | 4-24-95 | | | | |
| | Lot: | 457-084 | | | | |
| | Mfg: | Leader | | | | |
| | Site: | Rectal | | | | |
| | Initials: | BR | | | | |
| Flu | Date: | | | | | |
| | Lot: | | | | | |
| | Mfg: | | | | | |
| | Site: | | | | | |
| | Temp: | | | | | |
| Pneumococcal | Date: | | | | | |
| | Lot: | | | | | |
| | Mfg: | | | | | |
| | Site: | | | | | |
| | Temp: | | | | | |
| Hepatitis B | Date: | | | | | |
| | Lot: | | | | | |
| | Mfg: | | | | | |
| | Site: | | | | | |
| | Temp: | | | | | |
| Other: | Date: | | | | | |
| | Lot: | | | | | |
| | Mfg: | | | | | |
| | Temp: | | | | | |
| | Initials: | | | | | |

| Initials | Signature | Initials | Signature | Initials | Signature |
|----------|-------------|----------|-----------|----------|-----------|
| BR | [Signature] | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

Inmate Immunization Record
Commonwealth of Pennsylvania
Department of Corrections
DC-486

Inmate Name:

PEAY, STRATTON

Inmate Number:

DP-4246

DOB:

DOB: 11/04/76

Institution:

1 TUBERCULOSIS SUMMARY RECORD

This record will be initiated at hire/reception and updated by each facility throughout employment/incarceration.

4/24/98

Tuberculosis History: (to be completed at time of hire/reception)

Current Symptoms of TB: ☒ None ☐ Cough ☐ Fever ☐ Night Sweats ☐ Weight Loss
☐ Malaise ☐ Other

Multidrug Resistant?

| | No | Yes | If Yes, Date | Yes | No | Not Known |
|---|-------------------------------------|--------------------------|--------------|--------------------------|--------------------------|--------------------------|
| Known Previous Positive PPD? | <input checked="" type="checkbox"/> | <input type="checkbox"/> | | N/A | N/A | N/A |
| Known Prior History of TB Exposure? | <input checked="" type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Known Prior History of TB Disease? | <input checked="" type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Known Completion of TB Preventive Therapy? | <input checked="" type="checkbox"/> | <input type="checkbox"/> | | N/A | N/A | N/A |
| Known Completion of Therapy for TB Disease? | <input checked="" type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Treatment for TB During Incarceration

| | No | Yes | Offered but Refused | Drugs/ | Dates/Comments |
|-----------------------------|--------------------------|--------------------------|--------------------------|--------|----------------|
| Preventive Therapy? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Therapy for Active Disease? | <input type="checkbox"/> | <input type="checkbox"/> | N/A | | |
| Therapy After DOC Release | <input type="checkbox"/> | <input type="checkbox"/> | N/A | | |
| HIV Testing: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | |

Post Release DOT Appointment: Date: _____ Place: _____

Local DOH/County Health Dept. (notified): Date: _____ Initials: _____

| PPD RECORD | | SITE | DATE READ | | SIZE |
|--------------|------------------|-----------|-----------|----------------|------|
| DATE PLANTED | | | DATE | SIGNATURE | |
| 4/24/98 | S. [Signature] | 3 forearm | 4/27/98 | [Signature] | 0 mm |
| 4/6/98 | T. [Signature] | (R) FA | 5-8-98 | [Signature] | 0 mm |
| 4/30/99 | T. MARTYENKO, RN | (L) FA | 7/2/99 | T. MARTYENKO | 0 mm |
| 4/26/00 | [Signature] | LFA | 4/28/00 | [Signature] | 0 mm |
| 4/17/01 | B. [Signature] | LFA | 4/20/01 | B. [Signature] | 0 mm |
| 4/22/02 | B. [Signature] | LFA | 4/24/02 | B. [Signature] | 0 mm |

4-30-98

TB Summary Record
 Commonwealth of Pennsylvania
 Department of Corrections
 DC-469

Employee/Inmate Name: PEAY, STRATTON
 DP-4246
 Employee/Inmate Number: DOB: 11/04/76
 DOB:
 Institution: SCI/GRATERFORD

| | | | | | |
|--------------------|--------------------|----------|---------------------|---------|----|
| 1 Candida | Date test applied: | initials | Manufactures/Lot #: | | |
| | Date test read: | initials | Anatomic site: | Result: | mm |
| Trichophyton/Mumps | Date test applied: | initials | Manufactures/Lot #: | | |
| | Date test read: | initials | Anatomic site: | Result: | mm |
| 2 Candida | Date test applied: | initials | Manufactures/Lot #: | | |
| | Date test read: | initials | Anatomic site: | Result: | mm |
| Trichophyton/Mumps | Date test applied: | initials | Manufactures/Lot #: | | |
| | Date test read: | initials | Anatomic site: | Result: | mm |
| 3 Candida | Date test applied: | initials | Manufactures/Lot #: | | |
| | Date test read: | initials | Anatomic site: | Result: | mm |
| Trichophyton/Mumps | Date test applied: | initials | Manufactures/Lot #: | | |
| | Date test read: | initials | Anatomic site: | Result: | mm |

| Date X-ray Taken | Result Code * / Comment | Date X-ray Taken | Result Code * / Comment |
|------------------|-------------------------|------------------|-------------------------|
| 4.27.98 (1) | | | |
| | | | |
| | | | |
| | | | |

* X-ray Codes: 1 = Normal 2 = Abnormal, consistent with active TB disease 3 = Abnormal, consistent with inactive prior TB disease
4 = Abnormal, but not indicative of TB disease 5 = Converter 6 = Contact Investigation 7 = Cavitory 8 = Non-Cavitory

[illegible]

DENTAL RECORD

| | |
|--|---|
| Purpose of Examination <input checked="" type="checkbox"/> Initial <input type="checkbox"/> Other (Specify): | |
| Type of Examination (Circle one): 1 2 3 4 | PULHEST Classification (Circle one): 1 2 3 4 5 |

| INITIAL EXAMINATION: Missing Teeth and Existing Restorations <div style="text-align: center;"> <p>Lingual</p> </div> <div style="text-align: center;"> <p>Facial</p> </div> | Medical History <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th>Y</th> <th>N</th> </tr> </thead> <tbody> <tr><td>Heart Trouble.....</td><td>()</td><td>()</td></tr> <tr><td>High Blood Pressure.....</td><td>()</td><td>()</td></tr> <tr><td>Rheumatic Fever.....</td><td>()</td><td>()</td></tr> <tr><td>Asthma.....</td><td>()</td><td>()</td></tr> <tr><td>Diabetes.....</td><td>()</td><td>()</td></tr> <tr><td>Tuberculosis.....</td><td>()</td><td>()</td></tr> <tr><td>Hepatitis.....</td><td>()</td><td>()</td></tr> <tr><td>Epilepsy.....</td><td>()</td><td>()</td></tr> <tr><td>Psychiatric Treatment.....</td><td>()</td><td>()</td></tr> <tr><td>Excessive Bleeding.....</td><td>()</td><td>()</td></tr> <tr><td>Anemia.....</td><td>()</td><td>()</td></tr> <tr><td>Venereal Disease.....</td><td>()</td><td>()</td></tr> <tr><td>Allergies (Identify).....</td><td>()</td><td>()</td></tr> </tbody> </table> Institution: <u>SLC</u> Signature: <u>J. Selcher, DDS</u> Date: <u>5-8-98</u> Time: <u>1359</u> | | Y | N | Heart Trouble..... | () | () | High Blood Pressure..... | () | () | Rheumatic Fever..... | () | () | Asthma..... | () | () | Diabetes..... | () | () | Tuberculosis..... | () | () | Hepatitis..... | () | () | Epilepsy..... | () | () | Psychiatric Treatment..... | () | () | Excessive Bleeding..... | () | () | Anemia..... | () | () | Venereal Disease..... | () | () | Allergies (Identify)..... | () | () |
|---|---|-----|---|---|--------------------|-----|-----|--------------------------|-----|-----|----------------------|-----|-----|-------------|-----|-----|---------------|-----|-----|-------------------|-----|-----|----------------|-----|-----|---------------|-----|-----|----------------------------|-----|-----|-------------------------|-----|-----|-------------|-----|-----|-----------------------|-----|-----|---------------------------|-----|-----|
| | Y | N | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Heart Trouble..... | () | () | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| High Blood Pressure..... | () | () | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Rheumatic Fever..... | () | () | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Asthma..... | () | () | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Diabetes..... | () | () | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Tuberculosis..... | () | () | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Hepatitis..... | () | () | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Epilepsy..... | () | () | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Psychiatric Treatment..... | () | () | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Excessive Bleeding..... | () | () | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Anemia..... | () | () | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Venereal Disease..... | () | () | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Allergies (Identify)..... | () | () | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

| | |
|---|---|
| Diseases & Abnormalities <div style="text-align: center;"> <p>Lingual</p> </div> <div style="text-align: center;"> <p>Facial</p> </div> | CALCULUS: <input checked="" type="checkbox"/> Slight <input type="checkbox"/> Moderate <input type="checkbox"/> Heavy PERIODONTITIS: <input type="checkbox"/> Local <input checked="" type="checkbox"/> General <input checked="" type="checkbox"/> Incipient <input type="checkbox"/> Moderate <input type="checkbox"/> Severe STOMATITIS (Specify): <input checked="" type="checkbox"/> Gingivitis <input type="checkbox"/> ANUG DENTURES NEEDED: (Include dentures needed after indicated extractions) <input type="checkbox"/> Full Upper <input type="checkbox"/> Full Lower <input checked="" type="checkbox"/> NO <input type="checkbox"/> Partial Upper <input type="checkbox"/> Partial Lower Indicate X-Rays used in this examination <input type="checkbox"/> Full Mouth Periapical <input type="checkbox"/> Posterior Bite-Wings <input checked="" type="checkbox"/> Other (Specify) <u>Panograph</u> This is only to be signed if x-rays were taken to complete this examination. Institution: <u>SCI-Graterford</u> Signature: <u>Ronald Burkholder</u> RONALD BURKHOLDER, D.I. Date: <u>17 Mar 2000</u> Time: |
|---|---|

| | |
|--|---|
| Dental Record Commonwealth of Pennsylvania Department of Corrections DC-458 | Inmate Name: <u>Peay, Skatton</u> Inmate Number: <u>DP 4246</u> DOB: <u>11-4-76</u> |
|--|---|

PROBLEM LIST

| Prob. Letter | Date | Chronic Problems | ICD-9-CM |
|--------------|---------|---------------------------|----------|
| A | 4/24/96 | Hx. B.S.W. to Abd. x 2/29 | 959.1 |
| B | 8/24/01 | Chronic Abdominal | 789.0 |
| C | 6/02 | Chronic Constipation | |
| D | | | |
| E | | | |
| F | | | |
| G | | | |
| H | | | |

| Prob # | Date | Temporary Problems | Recurrence Date | | | | | ICD-9-CM |
|--------|---------|---|-----------------|---|---|---|---|--------------|
| | | | 1 | 2 | 3 | 4 | 5 | |
| 1 | 1/96 | S/P abd exploratory 2° SSW | | | | | | |
| 2 | 9/99 | Oth (R) | | | | | | |
| 3 | 1/00 | Monin of pleural shift | | | | | | |
| 4 | 1/00 | Dysphagia | | | | | | |
| 5 | 4/00 | throat capsule | | | | | | |
| 6 | 7/5/00 | Inmate states "I feel dizzy, I think I have a cold" | | | | | | 780.4 460 |
| 7 | 7/6/00 | Truncalitis | | | | | | 490 |
| 8 | 10/00 | falling out of bed | | | | | | 404.8 |
| 9 | 11/2/00 | also allergic to milk | | | | | | |
| 10 | 1 | nut. combination | | | | | | |
| 11 | 1/2/00 | URTI | | | | | | 465.9 |
| 12 | 1/01 | Pro Depression | | | | | | 311 |
| 13 | 5-00 | Gastroenteritis | | | | | | 558.01 |
| 14 | 6/01 | LBP | | | | | | 724.2 |

15

Signature of Dr. [unclear]

Problem List
Commonwealth of Pennsylvania
Department of Corrections
DC - 467

Inmate Name:

PEAY, STRATTON

Inmate Number:

DP-4246

DOB:

DOB: 11/04/76

Institution: